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Hospitals and Medical Debt:

A Report on Policies and Practices

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Contents

Authors

Marya Khan, M.P.H.; Taylor Dunlap; Kelsey Chalmers, Ph.D.; Eva Stahl, Ph.D.; Elizabeth Cope, Ph.D., M.P.H.

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Executive Summary

Up to 41% of Americans are estimated to have medical debt, broadly defined to include past due medical or dental bills as well as payments made over time to providers, financed through credit cards or other lending avenues.[1] The burden of medical debt has wide-ranging consequences for patients and their families, including delaying health care, depleting savings, diminishing physical and mental health, increasing mortality, and eroding trust in health care.[1-3] Federal and state policies have provided some protections, although progress has been uneven.

Hospitals have addressed medical debt through their financial assistance programs and by curtailing the use of aggressive collection actions. To better understand hospital efforts, AcademyHealth, with funding from the ABIM Foundation, conducted a two-part environmental scan consisting of 1) a literature review; and 2) key informant interviews. The environmental scan addressed two research questions: 1) what is the nature and prevalence of health system policies and practices related to medical debt mitigation and collection; and 2) what is the impact of these policies and practices on patients and clinicians?

By identifying priorities for further research and highlighting effective and promising approaches for addressing medical debt, this report is intended to aid health system leaders, researchers, clinicians, and patient and community groups working to address medical debt.

Background on Federal Regulations

Under federal law and the Affordable Care Act (ACA), nonprofit hospitals must adopt and publicize a financial assistance policy, sometimes known as a charity care policy, that defines eligibility criteria for free or discounted care.[4] However, there are no federal standards about how generous those policies must be, with no required minimum eligibility thresholds or benefit amounts.[5] Federal protections related to medical debt collection are also limited. Nonprofit hospitals can take extraordinary collections actions (ECAs) against patients once they have made a "reasonable effort" to assess a patient's eligibility for financial assistance. ECAs include credit reporting, selling debt to third parties, denying non-emergent care, and taking legal action through such means as lawsuits, wage garnishment, and property liens.[5]

What We Know: Addressing Medical Debt

Key strategies for mitigating medical debt include:

- hospital financial assistance,
- Hospital Presumptive Eligibility (HPE) for temporary Medicaid coverage,
- financial navigation services, and
- medication-focused assistance.

Research has found these strategies to be effective, with increased patient access to care, cost savings, and improved health outcomes.[6-13] Strategies for addressing medical debt collection focus on ethical billing practices, including itemized billing and avoiding legal action.[14] Recent research has shown a decline in ECAs, such as credit reporting, lawsuits, wage garnishments, and liens.[15-17] However, in the absence of standardized federal requirements, considerable variation remains, and research has highlighted misalignment between factors such as hospital financial performance and levels of financial assistance provided, or the value of tax benefits and levels of financial assistance provided.[18-22]

Understanding hospital behavior requires looking beyond policies and practices to broader structural factors, as hospitals face a number of pressures that may complicate their ability and willingness to prioritize addressing medical debt. These include pressures related to financial sustainability, the role of payers and insurance, influence of private equity, and heath policy. Among the multitude of factors at play, the high cost of health care was highlighted as a key underlying factor in the creation of medical debt.

What We Do: Current Hospital Policies and Practices

While the evidence identifies strategies that can help mitigate medical debt, hospital actions vary widely, with discrepancies between hospital policies and actual practices, and between evidence-based strategies and current practice. More than 80% of hospital policies indicate they provide free and discounted care, but eligibility criteria vary substantially.[23] In terms of actual financial assistance provided, 45% of hospitals spend less than 1% of their operating expenses on financial assistance.[24] When it comes to medical debt, over half of hospitals (59%) permit at least one kind of ECA, while only a small minority (4%) do not permit any.[23] Evidence on actual debt collection practices is limited and fragmented. However, research has indicated that one-third of hospitals report taking legal action against patients.[25]

States play a critical role in addressing medical debt through policy protections, but fewer than half of states set a minimum amount of financial assistance that hospitals should provide. For states that regulate debt collection, protections also vary, with some states imposing specific limits on ECAs and others prohibiting them outright.[5]

What We Need to Know: Key Evidence Gaps

Understanding the full scope of medical debt requires more comprehensive and standardized data across several sources, including hospitals, credit reporting agencies, courts, and state-level data collection. Significant gaps remain in estimates of the prevalence of medical debt, hospital reporting practices, financial transparency, and evaluations of existing interventions as outlined in the table below:

Key Evidence Gaps

Topic	What is Missing
Population-Level Data	
Prevalence of Medical Debt	Full extent of medical debt remains unclear, as medical debt takes many forms and is inconsistently measured, with most surveys capturing only partial indicators
Credit Reporting	Credit data are largely proprietary and held by private credit bureaus, creating high administrative barriers and costs to researchers
Court Records on Medical Debt	Litigation data are difficult to compile given inconsistent digitization and unclear identification of originating providers
Credit Card Data	Extent of medical debt that exists on credit cards to pay medical bills, which is technically considered financial debt
Hospital-Level Data	
Financial Assistance Applications	Hospitals do not routinely report on the number of financial assistance applications attempted, completed, and approved, including patient demographics, although some states have started to require reporting on these data
Debt Collection Practices	Hospitals do not routinely report on the number of patients with unpaid bills, the debt size, insurance status, and the number of ECAs, including patient demographics
Hospital Financial Transparency	Despite Internal Revenue Service (IRS) and other reporting requirements, there is limited hospital financial transparency, such as information on assets, reserves, and profits, and there is lack of consensus about which data would be most meaningful to track
Hospital Operational Expenses and Revenue	Given the complexity of hospital financial administrative processes, there is limited insight into distributions of revenue (e.g., what percentage goes to the hospital vs physicians vs third parties)
Return on Investment of ECAs	While available data suggest a limited benefit to pursuing ECAs, rigorous research is needed to assess return on investment of various debt collection practices and whether this varies across hospital types [26,27]
Landscape of Financial Tools	Lack of transparency of vendors and products (e.g., presumptive eligibility tools, revenue cycle management companies, medical credit cards) that hospitals are using, and market share
Research/Evaluation Studies	
State Policies	Variations in enforcement, implementation, and consumer awareness make it difficult to evaluate state policy protections, including making the business case
Programmatic Interventions	Rigorous evaluations are needed to assess different programs for addressing medical debt (e.g., financial navigation programs)
Business Case for Underfunded Services	Rigorous evidence quantifying the economic and broader societal value of underfunded health care services, such as preventive care and palliative care

What We Can Do Now: Effective and Promising Approaches

Even as research continues, our environmental scan revealed valuable insights into effective and promising approaches for reducing medical debt, including:

Approaches That Hospitals Can Lead

1. **Patient-Centered Financial Assistance and Other Programs**
   - Optimize financial assistance to improve both eligibility and access issues
   - Hospital participation in Hospital Presumptive Eligibility (HPE) programs for temporary Medicaid coverage, although recent and pending health policy changes may present a more complex environment for providing such coverage, along with serious implications for the privacy and security of patient Medicaid data
   - Staff support to help patients manage costs of care, apply for health insurance and medication assistance, and coordinate with care teams and clinicians
   - Offer sliding-scale, zero-interest payment plans and avoid predatory medical credit cards[28]
2. **Ethical Billing and Responsible Debt Collection**
   - Adopt ethical billing practices and avoid aggressive collections
   - Engage with all hospital contracted entities to ensure that consistent billing ethics and socially responsible financial practices are in place
3. **Organizational Leadership, Culture, and Decision-Making**
   - Engage hospital leaders who consider the hospital's broader role and impacts in the community
   - Focus on a hospital's mission of improving people's health, while also considering the value of ensuring financial resources remain in communities for the well-being of both patients and the institution
   - Engage clinicians, the community health or community benefit department, hospital social workers, hospital boards, and patient and community representatives in determining hospital financial policies (e.g., financial assistance and debt collection)
   - Consider trust as a unifying force as both hospital leaders and clinicians may experience a loss of trust with the increasing corporatization of health care
4. **Partnerships with Community-Oriented Organizations**
   - Partner with community organizations to streamline processes and offer support in such areas as financial assistance navigation, cultural sensitivity, and debt relief
   - Explore the potential for investing in financial products developed under a patient-centered model focused on public benefit, such as billing services that provide support for achieving administrative efficiencies without engaging in predatory practices

Approaches That Require Broader, External Leadership

5. **Engaging Policy, Industry, and Public Support**
   - Establish state requirements for financial assistance reporting and/or minimum financial assistance spending, along with medical debt protections and reporting[29,30]
   - Maintain mandatory state or voluntary industry billing standards
   - Highlight model financial assistance policies for hospitals to adopt or adapt
   - Develop a list of vendors vetted at the state or federal level, for example for financial navigation services or revenue cycle management companies
   - Hold insurers accountable for plan design and affordable insurance[3]
   - Draw wider media and public attention to medical debt and the impacts of aggressive debt collection practices

Medical debt and prohibitively costly care undermine trust and must be confronted. While policy debates about health care financing are ongoing, health services researchers, health system leaders, and other partners can take meaningful steps now to rebuild trust and focus on an issue that impacts so many. By adopting patient-centered financial assistance and ethical billing practices, hospitals can play a critical role in leading this effort. However, lasting change requires collective action—especially in the current health policy and financial environment—bringing all who are affected to the table to develop an attainable, just, and equitable approach to addressing medical debt.

Introduction

Medical debt in the United States reflects longstanding gaps in health care financing, shaped by policies at both federal and state levels. Hospitals, as primary providers of care that is often complex and costly, play a significant role in this system while navigating complex financial structures. Unlike most high-income countries that have universal insurance coverage, the United States relies on a mix of employer-sponsored coverage, individual insurance, and fragmented public programs, which leave millions of people uninsured and at high risk of medical debt. Rising health care costs and prices, along with high deductibles and out-of-pocket costs, mean that even those who have insurance are at increased risk.[31] Medical debt has become one of the most pervasive financial burdens facing households in the United States.[32]

Up to 41% of Americans are estimated to have medical debt, broadly defined to include past due medical or dental bills as well as payments made over time to providers that are financed through credit cards or other lending avenues.[1] The burden of medical debt has wide-ranging consequences for patients and their families, including cutting back on basic necessities, skipping or delaying health care, and depleting savings.[1] And the consequences extend beyond patient finances, as medical debt is associated with diminished physical and mental health, increased mortality, and erosion of trust in health care.[2,3] While medical debt is widespread, it disproportionately affects low-income households, women, Black and Hispanic adults, and residents of Southern states—reflecting longstanding inequities in insurance coverage and access to affordable, high-quality care.[1]

Policies enacted over the past several decades have provided some protections against medical debt, although progress has been uneven (see Figure 1 for an overview of the policy landscape). The Affordable Care Act (ACA), including its Medicaid expansion provisions, has reduced uninsured rates, and the No Surprises Act (NSA) eased some financial burdens by eliminating surprise billing, but these gains have been uneven and have not eliminated the risk of catastrophic medical bills.[33,34] Most recently, passage of the 2025 Budget Reconciliation Law is projected to reverse many of these gains, with anticipated losses in health coverage, higher uncompensated care costs, and increased financial strain on hospitals.[35]

At a time of deep political polarization, medical debt is an issue that unites Americans across party lines, as highlighted by a recent study from Undue Medical Debt: 76% of voters support state laws protecting people from medical debt, almost 70% say health care costs are unaffordable, and over half (57%) report that mental stress and anxiety from medical debt are the most difficult part of the experience.[36] Given the widespread impacts, addressing medical debt will require a concerted effort that draws on federal and state protections and calls on all who are impacted, including hospitals, payers, clinicians, patients, and communities to collectively explore and implement strategies to mitigate medical debt.

To gain a better understanding of hospital medical debt mitigation, AcademyHealth, with funding from the ABIM Foundation, launched a two-year project in November 2024 focused on understanding health system medical debt policies and practices. This work builds on a June 2024 report and convening by the ABIM Foundation, Addressing Medical Debt: Rebuilding Trust in Health Care.[45] AcademyHealth is working on the current project in collaboration with two scholars in residence, Kelsey Chalmers, Ph.D., Director of Research, Data Science at the Lown Institute and Eva Stahl, Ph.D., Vice President, Policy, Engagement & Research at Undue Medical Debt.

The first year of this project focused on an environmental scan to gain understanding of hospital policies and practices related to medical debt. Examining the literature, we assessed debt mitigation and collection policies and practices as well as their associated outcomes. We conducted key informant interviews to validate findings from the literature and identify and fill gaps, surface priorities for further research, and highlight promising approaches for addressing medical debt, with a focus on the role of health systems.

This report is intended to aid health system leaders, researchers, clinicians, and patient and community groups working to address medical debt.

The second year of the project will focus on opportunities for promoting the adoption of ethical medical debt policies and practices in health systems.

Figure 1. **Policy Landscape**

1986	Emergency Medical Treatment & Labor Act (EMTALA) requires Medicare-participating hospitals to provide medical screening and stabilizing treatment to anyone who presents to an emergency department, regardless of ability to pay.[37]	
EMTALA Passes	**Implications**	Ensures access to emergency care but can leave patients with uncovered bills.
March 2010	Affordable Care Act (ACA) expands health insurance coverage and offers some protections. Internal Revenue Service (IRS) regulations set by the ACA required nonprofit hospitals to adopt written financial assistance policies and follow fair billing/collection practices, effective Dec. 29, 2015..[38]	
ACA Enacted	**Implications**	Reduces the likelihood that patients would incur medical debt, especially among those who gained coverage through Medicaid.
June 2012	Upholds the ACA while making Medicaid expansion optional by limiting the U.S. Department of Health and Human Services' ability to withhold existing Medicaid funds from states that refused to expand.[39]	
NFIB v. Sebelius	**Implications**	Creates variation across states in uptake of Medicaid expansion, increasing the likelihood of medical debt exposure for patients in non-expansion states.
Dec 2020	No Surprises Act (NSA) prohibits surprise billing for many out-of-network services, including emergency care.[40]	
NSA Passes	**Implications**	Patients less likely to receive unexpected bills, though challenges with enforcement persist.
2022–2023	Three major credit-reporting agencies voluntarily change how they report medical debt, including removing paid collections and no longer reporting balances under $500.[41]	
Credit Reporting Changes	**Implications**	Removing a substantial share of medical collection accounts has the potential to improve many consumers' credit reports.
Jan–July 2025	Consumer Financial Protection Bureau (CFPB) final rule in January 2025 bans medical debt on credit reports and lenders from using medical debts in lending decisions.[42] Following a challenge in court, a federal judge vacates the rule in July 2025.[43] In late 2025, the CFPB issues nonbinding guidance suggesting that the Fair Credit Reporting Act may limit states' ability to restrict medical debt reporting; the guidance is being challenged in court.[44]	
CFPB Rule Issued, Overturned	**Implications**	Credit bureaus and lenders are still able to report and use medical debt in lending decisions, and state-level protections for medical debt reporting remain uncertain.
July 2025	Among many provisions, 2025 Budget Reconciliation Law reduces Medicaid funding and ACA subsidies.[35]	
Budget Reconciliation Law	**Implications**	Likely to increase medical debt, particularly among populations that lose coverage or face higher out-of-pocket costs, along with increased uncompensated care costs for hospitals.

Methods

The team conducted an environmental scan consisting of 1) a literature review; and 2) key informant interviews, to address the following two research questions:

- What is the nature and prevalence of health system policies and practices related to medical debt mitigation and collection?
- What is the impact of these policies and practices on patients and clinicians?

Literature Review

Comprising the first phase of the environmental scan, the team conducted a literature review between December 2024 and June 2025. The review entailed a structured search of peer-reviewed literature using PubMed as well as complementary techniques to identify other relevant reports and resources in the grey literature, using Google searches and informed by suggestions from subject matter experts. See Appendix A for details about the search strategy and process for article review and analysis.

Key Informant Interviews

A second phase of the environmental scan entailed primary data collection via key informant interviews conducted between June and August 2025. Scholars in residence and other partner networks recommended key informants, and the team interviewed experts representing academia, clinical care, health systems, associations, organizing, and policy. Eighteen interviews were conducted.

The team used preliminary literature review results to develop a discussion guide with nine interview questions shared with each key informant prior to the interview. The discussions were aimed at gaining a better understanding of existing efforts in the field, including promising approaches and barriers to progress. Details about the discussion topics and the interview process and analysis are provided in Appendix A.

Scope of Research and Findings

We acknowledge that multiple factors, such as federal and state policies, insurance practices, and the complexity of health care financing, all have a critical role to play in how health systems approach the issue of medical debt. In this report, we reference and discuss these factors as contributors to the medical debt landscape, but we center our focus on policies and practices issued by health systems for medical debt mitigation and medical debt collection.

We have divided our environmental scan findings into three sections:

1. What we know about effective health system approaches to addressing medical debt as well as system-level drivers.
2. What we know about actual health system policies and practices related to medical debt.
3. Priorities for learning and action to address data gaps and implement effective and promising approaches.

What We Know: Addressing Medical Debt

Available research provides important insights into opportunities for addressing medical debt. Hospitals play a central role in how medical debt is managed, both in terms of providing financial assistance to eligible patients and collecting payments. This section provides an overview of evidence for strategies that have demonstrated the potential to reduce the burden of medical debt.

Background on Federal Regulations

Under federal law and the Affordable Care Act (ACA), nonprofit hospitals must adopt and publicize a financial assistance policy, also known as a charity care policy, that defines eligibility criteria for free or discounted care.[4] They must also annually submit Form 990 Schedule H, which reports eligibility limits for free and discounted care, the budgeted and actual dollar amounts spent on financial assistance and other community benefits, and the total dollar amount written off as bad debt. However, there are no federal standards about how generous those policies must be, with no required minimum eligibility thresholds or benefit amounts, and hospitals are not required to report how many patients apply for or receive assistance. Additionally, these requirements do not apply to for-profit hospitals.[5]

Federal protections related to medical debt collection are limited. Nonprofit hospitals can take extraordinary collections actions (ECAs) against patients once they have made a "reasonable effort" (quoted from the IRS Section 501(r)(6)) to assess a patient's eligibility for financial assistance, and they are not required to report on the number of ECAs initiated. ECAs include credit reporting, selling debt to third parties, denying non-emergent care, and taking legal action through such means as lawsuits, wage garnishment, and property liens.[5]

Evidence on Hospital Strategies

Evidence drawn primarily from the peer-reviewed literature portion of the environmental scan about hospital strategies to mitigate medical debt and address medical debt collection practices is presented below. The number of studies is limited, precluding a more in-depth examination. We identify several themes from the literature and note the key areas in which the interviews affirmed the literature review findings.

Proactive Patient Assistance

Key strategies for mitigating medical debt include:

- provision of hospital financial assistance;
- participation in Hospital Presumptive Eligibility (HPE) programs, which allow hospitals to provide individuals likely to be eligible for Medicaid with temporary coverage (up to two months), with the potential for ongoing coverage;
- more comprehensive financial navigation services;
- medication-focused assistance; and
- hospital payment plans for non-emergent care.

An overview of these strategies is outlined in Table 1, along with associated outcomes and implementation enablers and barriers (the full, detailed table with references is available in Appendix B).

Associated Outcomes

Research has found that strategies for mitigating medical debt are associated with increased patient access to care, cost savings, and improved health outcomes.[6-13]

Enabling Factors

A key facilitator for financial assistance programs has been the implementation of state regulations, including requirements for minimum community benefit spending or detailed reporting on financial assistance spending.[46-48] Other enabling factors include programs focused on specific health conditions, such as cancer treatment or bariatric surgery, which have involved clinician engagement through conversations about cost with patients or structural efforts to limit costs of care and leverage external financial assistance programs.[6,49] Notably, by improving access to care, financial assistance has been found to address treatment-sensitive conditions, supporting high-value care. These improvements can contribute to better health outcomes and may prevent more costly treatments in the future.[6,50]

Other specialized programs, such as those focused on HPE, financial navigation, or medication assistance, have provided a broader range and depth of services. Hospital participation in HPE programs, for example, is a vital strategy for mitigating medical debt, as these programs have been effective in providing temporary Medicaid and often lead to continued enrollment for eligible patients. HPE programs have been associated with cost savings for patients, as well as reduced uncompensated care costs for hospitals.[51,52] Hospital leaders have supported HPE participation as a means to reduce hospital bad debt (i.e., charges the hospital considers uncollectible), improve patient satisfaction, and save resources and time that would have otherwise been spent collecting from patients with a low likelihood of payment.[51]

Financial navigation services, often offered in the context of cancer care, provide more comprehensive support for patients, families, and caregivers. Such services may include support in applying for financial or medication assistance, assistance in obtaining insurance, direct financial support for medical and nonmedical costs, and educating patients about financial aspects of care.[53] The biggest driver for mitigating medical debt within these programs appears to be the direct efforts to reduce patient costs. In addition, these navigation programs are associated with broader improvements, including better understanding of available financial resources and reduced anxiety.[7]

Medication-focused assistance programs that provide support via sources such as foundations, pharmaceutical companies, and federal and state government programs were also found to be effective, with associated improvements in medication adherence, reduced hospital utilization, and patient cost savings.[11,12,54] The risk of medical debt from pharmaceuticals was highlighted as a growing concern by key informants, particularly with increasing use of new high-cost drugs, such as GLP1s and cancer drugs. Finally, payment plans for non-emergent care present a potential strategy for mitigating medical debt, although the evidence in this area is more limited.[55]

These specialized programs of HPE, financial navigation, and medication-focused programs offer the potential to strengthen current debt mitigation efforts. Common features across these programs include their emphasis on dedicated staffing support for patients, collaboration among the health care team and

clinicians as needed, and in some cases support from external partners that help extend staffing capacity.[7,9,10,56-58] Drawing on these varied programs and the additional supports they provide presents an important opportunity for bolstering hospital financial assistance programs.

Barriers

While these programs provide important support, a number of barriers continue to hamper current financial assistance efforts. These include complicated and burdensome application processes, limited patient awareness of available resources, and wide variation both in eligibility criteria for hospital financial assistance and in levels of financial assistance spending.[18-20,22,59-62]

Hospitals also operate within a range of contextual factors, such as their financial performance, tax status, payor mix, patient population, and location—all of which may influence their policies and capacity to mitigate medical debt. Numerous studies have sought to examine the association between hospital characteristics and financial assistance, often with mixed results.[19,20,22,63-66] Importantly, research has highlighted misalignment between factors such as hospital financial performance and levels of financial assistance spending, or value of tax benefits and levels of financial assistance spending.[18-22] Increased profits do not necessarily translate to increased spending on financial assistance.[22] Additionally, most nonprofit hospitals receive more in tax exemptions than they spend on financial assistance.[18,21] Studies have also indicated that hospitals may set and adjust the parameters of their financial assistance policies based on a predetermined target for the amount of financial assistance they aim to provide.[61,67]

Key informants further emphasized severe disparities in the amount of financial assistance hospitals provide, attributing this to a confluence of factors. For instance, more generous income eligibility thresholds coupled with burdensome application processes may generate lower amounts of charity care than less

Table 1. Mitigating Medical Debt

Financial Assistance

Overview: Hospitals provide assistance in the form of free or discounted care, also known as charity care, to eligible patients. Nonprofit hospitals are required under federal law to meet a community benefit standard, which includes financial assistance, to maintain tax-exempt status. The ACA also requires nonprofit hospitals to develop and publicly share their financial assistance policy.

Associated Outcomes
- Increased patient health care utilization, including high-value care
- Patient cost savings and improved patient health outcomes
- Higher hospital eligibility limits for financial assistance and increased hospital financial assistance spending

Implementation Enablers
- State requirements for minimum community benefits+
- State requirements focused specifically on financial assistance reporting+
- Programs focused on specific health care conditions and featuring clinician support

Implementation Barriers
- Limited patient awareness of financial assistance; unclear policies and complex applications+
- Patient fear that seeking aid could affect care
- Limited federal requirements for level of financial assistance hospitals must provide+
- Varied eligibility criteria and financial assistance spending that may not align with financial performance or tax benefits+

Hospital Presumptive Eligibility (HPE)

Overview: Allows hospitals to provide individuals likely to be eligible for Medicaid with temporary coverage (up to two months) with the potential for ongoing coverage. All states are required to have an HPE program under the ACA, but hospital participation is optional.

Associated Outcomes
- Temporary Medicaid coverage and enrollment to maintain coverage at six months
- Increased net Medicaid revenue and reduced uncompensated care costs for hospitals+

Implementation Enablers
- Dedicated staff for application support+
- Third-party vendors for application and follow-up support
- COVID-era policies for expanded eligibility and remote approvals
- Hospital-reported incentives: reduced bad debt, patient satisfaction and care access, saved resources avoiding collections for patients with low propensity to pay

Implementation Barriers
- Complex application process and access barriers to online state HPE portal for hospital staff
- Patient knowledge gaps about insurance; fear of sharing personal information, e.g., regarding finances or immigration status
- Insufficient staff for patient screening and application submission, difficulty contacting patients post discharge

Note: + indicates statement was further supported by key informant interviews

Financial Navigation Services

Overview: Often offered in the context of cancer programs, these services provide support for patients, families, and caregivers to overcome financial barriers through application support for financial assistance, pharmaceutical assistance, and insurance; direct financial support with medical and nonmedical costs; and understanding financial aspects of their care, including budgeting and insurance benefits.

Associated Outcomes
- Increased patient knowledge of available financial resources, reduced anxiety
- Patient cost savings
- Reduced medical debt write-offs and lower levels of financial assistance spending for hospitals

Implementation Enablers
- Patient education and direct financial assistance for managing costs
- Staff support to apply for insurance and various financial aid programs, including outsourcing to external organizations
- Communication across care team, use of financial toxicity EMR order set

Implementation Barriers
- Patient hesitancy in admitting financial needs; limited understanding of out-of-pocket costs and managing expenses
- Limited trained navigators; clinician and staff hesitancy to discuss costs of care, lack of access to information about cost
- Clinical time and budget constraints

Medication-Focused Assistance Programs

Overview: Financial assistance programs focused on providing support for prescription medications, often via sources such as foundations, pharmaceutical companies, and federal and state government programs.

Associated Outcomes
- Patient access and adherence
- Reduced health care utilization, patient cost savings, improved health outcomes
- Increased hospital charity care spending (offset by other community benefits)

Implementation Enablers
- Staff assisting with patient enrollment[+]
- Coordination with clinicians
- Clinicians suggesting lower-cost medications, providing samples, and helping apply for drug assistance
- Long-term medication support (1 year)

Implementation Barriers
- Limited scope of formulary
- Patient hesitation in sharing personal financial information

Payment Plans (non-emergent care)

Overview: Options for patients to pay for health care services over time for non-emergent care.

Associated Outcomes
- n/a

Implementation Enablers
- Broad availability of payment plans by hospitals, and in some cases, their third-party vendors

Implementation Barriers
- Lack of centralized services
- Varied eligibility and payment timeframes, with some accruing interest or charging fees

Note: [+] indicates statement was further supported by key informant interviews

generous thresholds with easier applications. Similarly, generous income eligibility thresholds may not be effective if they are not well-publicized and patients are not aware of them. An added barrier is the potential impact of recent policy changes which may lead to increased patient hesitancy in sharing personal information, such as immigration status.

Ethical Strategies for Billing and Collections

Strategies for addressing medical debt collection focus on ethical billing practices, which include ensuring price transparency, providing itemized billing, and avoiding taking legal action against patients.[14] Details about these practices are outlined in Table 2, along with associated outcomes and implementation enablers and barriers (see Appendix B for the full table details with references).

Recent research has shown a decline in ECAs, including credit reporting, lawsuits, wage garnishments, and liens.[15-17] A key enabling factor has been increased media and public attention to debt collection practices.[17] Voluntary billing quality measures have also been established to support ethical billing practices, e.g., providing patients with itemized bills, instructions for contacting a billing representative, and refraining from taking legal action for late or insufficient payment.[25] Additionally, key informants indicated that changes by credit agencies limiting the reporting of medical debt may also be a potential factor. However, in the absence of standardized federal requirements, substantial variation in billing and collection practices remains.[15,16,25] Key informants also noted that while aggressive collections were declining, the consistency of the trend was unclear, and despite declines in litigation, credit reporting remains common.

Table 2. **Addressing Medical Debt Through Ethical Billing Practices**

Ethical Billing Practices		
Overview: Practices may include providing patients with itemized billing, instructions for contacting a billing representative, and not taking legal action against patients for late or insufficient payment.		
Associated Outcomes	**Implementation Enablers**	**Implementation Barriers**
• Decrease in ECAs, i.e., credit reporting, lawsuits, wage garnishments, and liens+ • Increase in levels of hospital bad debt/medical debt write-off • Better patient understanding of bills, receiving a payment plan, bill correction, and/or financial relief	• Increased media and public attention to debt collection practices+ • Introduction of voluntary industry billing standards+ • State legislation expanding medical debt protections+ • Patient self-advocacy	• Limited guidance for patients on managing medical debt and understanding legal protections+ • Varied billing and collection practices across hospitals, with a minority of large hospitals being responsible for the majority of litigation, and some hospitals viewing credit reporting and selling debt as standard practice+ • Low total hospital revenue

Note: + indicates statement was further supported by key informant interviews

State legislation has been found to offer some protection for patients against medical debt, although evidence on the impacts of these policies is limited. A recent study on Oregon's medical debt legislation revealed increased levels of hospital bad debt, which reflects the intent of the legislation: hospitals are writing off more medical debt, rather than pursuing collection.[68]

At the individual level, research has shown that patient self-advocacy is associated with positive outcomes, such as improved understanding of bills, access to payment plans, correction of billing errors, and/or receiving financial relief.[69] Unfortunately, broader programmatic support and guidance to help patients navigate medical debt and understand legal protections is limited.[53]

Research has shown that a majority of large U.S. hospitals (74%) do not sue patients, with many relying on less punitive approaches.[16] Other research has indicated that hospitals with lower total revenue are more likely to engage in aggressive collection practices. Study authors suggest this may be because lower-revenue hospitals are more dependent on these funds, and/or have limited internal billing capacity and greater reliance on third-party billing entities.[15]

Key informant interviews further supported these findings, noting a spectrum of hospital policies, from prohibiting aggressive collections to pursuing all debt collections. They also noted that health systems may employ aggressive collection practices to deter patients from accessing further services. Several key informants questioned the return on investment of aggressive collection practices, given the limited dollar amounts that can be recouped, and the considerable harm caused for patients. They emphasized that the involuntary nature of receiving many kinds of medical care, such as emergency care, the high costs of health care, and limited ability to understand and navigate the processes around medical debt leaves patients uniquely vulnerable with little recourse when facing aggressive collection actions.

System-Level Drivers

Understanding hospital behavior requires looking beyond policies and practices to broader structural factors. While the literature review portion of the environmental scan offered strategies for addressing medical debt, the key informant interviews provided a nuanced understanding of the complex environment in which hospitals are operating. By examining internal hospital operations and the broader hospital environment, this section provides a deeper understanding of the incentives and pressures that hospitals are facing, with implications for how hospitals address medical debt.

Internal Hospital Operations

Key areas of discussion that focused on internal hospital operations explored hospital financial sustainability, the highly complex nature of administrative processes inherent to hospital finances, the role of key decisionmakers, potential for using presumptive eligibility tools to automatically assess patient eligibility for financial assistance, and the use of revenue cycle management companies (RCMs) to oversee patient financial processes (see Table 3).

External Hospital Environment

In addition to exploring internal hospital operations, the key informant interview portion of the scan also addressed a range of broader factors that influence hospitals and their practices, as outlined in Table 4. Key issues focused on the role of payers and insurance coverage, the influence of private equity in health care, and the critical importance of heath policy.

Table 3. **Internal Hospital Operations**

Area of Focus	Key Points from Interviews
Hospital Sustainability	• Amid myriad conflicting pressures, a key priority for hospitals is ensuring their sustainability • While many large systems are operating with large margins and cash investment reserves, others are barely surviving • Maintaining sufficient margins is important for obtaining favorable bond ratings and lower interest rates, reinvesting in capital infrastructure, and withstanding financial fluctuations due to factors outside hospitals' control • Greater balance is needed in hospital incentive structures, so they are incentivized to meet both their margins and charitable mission
Complex Administrative Processes	• Complex, siloed nature of hospital administration makes it difficult to understand financial processes, assess impacts of the system, and identify opportunities for change • Hospital leaders or board may not be aware of the kinds of collections practices occurring, especially as these may be contracted out to third party agencies • As hospital leaders may be focused on ensuring financial sustainability, they may not realize the impacts that debt collection can have on patient outcomes and their subsequent ability to seek care
Key Hospital Decisionmakers	• Key decisionmakers addressing medical debt mitigation and collection are likely in positions of financial leadership or revenue cycle management • Others who may have varying degrees of involvement include the president or chief executive officer, chief information officer, chief medical officer, community health or community benefit department, general counsel, and the hospital board • While physicians may have had a greater decision-making role in the past, that no longer appears to be the case, although physicians may become involved on behalf of their patients
Presumptive Eligibility Tools[a]	• Presumptive eligibility tools that use predictive analytics to automatically assess a patient's eligibility for financial assistance can be used to screen all patients, with the potential to improve efficiency while removing application barriers for patients • Presumptive eligibility tools may be expensive, but some are advertised to hospitals as providing a return on investment because they can determine patients' propensity to pay and target debt collection activities, which may increase medical debt for patients • However, if used with established criteria and screening for patients who may otherwise not access financial assistance, presumptive eligibility tools have the potential to decrease medical debt • Cautions regarding use of these tools include privacy concerns around accessing personal data and potential biases in the algorithms that are often based on credit data, where low-income and minoritized populations are less represented
Revenue Cycle Management	• Hospitals often contract with revenue cycle management companies (RCMs) to oversee financial processes from initial patient encounter to final payment • RCMs are accustomed to leveraging various points of patient contact to collect payments, from making an appointment to viewing test results • While some RCMs are interested in addressing the impact of medical debt on patients, many engage in aggressive collection practices (that are usually determined by the client hospital

[a] *Presumptive eligibility tools to automatically assess financial assistance eligibility are different and distinct from Hospital Presumptive Eligibility (HPE) programs previously discussed for temporary Medicaid coverage.*

The Bottom Line: High Costs of Care

Among the multitude of factors at play, the high cost of health care was seen as a key underlying factor in the creation of medical debt. High prices were cited as a fundamental problem, reflecting a health care system that prioritizes costly treatments over preventive care and lacks sufficient price controls and transparency.

Insufficient investment in prevention was noted as a key driver of rising health care costs, as hospitals are incentivized to provide more expensive procedures and therapies, often driven by technological advancements in medical devices and pharmaceuticals. Additionally, substantial resources were noted to be concentrated in end-of-life care, rather than keeping people healthier earlier in life, where interventions could potentially prevent more costly care in the future.

While insurers were acknowledged to contribute to medical debt by exposing patients to large medical bills, hospitals were regarded as the largest drivers of cost in the system, with health care costs that are essentially unaffordable. Key informants also highlighted that while insurance providers are subject to cost-limiting regulations, such as the medical loss ratio, which requires a certain percentage of premiums to be spent on medical care, no such requirements exist for hospitals. Additionally, there are few mechanisms for transparency. For instance, it is often unclear whether a hospital's financial losses are due to unrealized investment losses or a loss in revenue, which present considerably different implications for the hospital.

Table 4. **External Hospital Environment**

Area of Focus	Key Points from Interviews
Payers and Insurance	• While medical debt is commonly believed to mostly affect the uninsured, individuals with insurance are also at risk • High deductibles and other insurance-related costs, coupled with insurance denials, mean insurance is often inadequate to cover the total costs of medical care • Hospitals are required to follow processes outlined in their contracts with payers when attempting to collect on payment • Inadequate insurance affects both patients and health systems, as the former are unable to afford such high costs and the latter are left to fill the gaps in coverage
Private Equity	• With the continued presence of private equity in health care, financial and business principles are increasingly influencing patient care • As hospitals contract with third party agencies to outsource financial risk, these third-party agencies, often owned by private equity, may be the key beneficiaries of these arrangements • Third party vendors, such as RCMs, not only receive large contracts from hospitals, but also gain access to large amounts of patient data • Private equity is a key player in medical credit cards, which may be promoted as helping patients afford health care, while having high interest rates and fees that can worsen medical debt
Health Policy Environment	• Recent policy changes, including cuts to Medicaid and enhanced premium tax credits, are altering the landscape of hospital finances • Hospitals that rely heavily on Medicare and Medicaid will be deeply affected, particularly in rural areas, with some hospitals being forced to close • Many people are expected to lose health coverage, contributing to delayed care, more acute conditions, increased health care spending, and ensuing medical debt • While hospitals will be hard-pressed to provide more financial assistance in this environment, it will also be impossible for patients to pay these increased costs • Additionally, recent data sharing requirements have serious implications for the privacy and security of patient Medicaid data

What We Do: Current Hospital Policies and Practices

While the evidence identifies strategies that can help mitigate medical debt, hospital policies and practices vary widely. This section provides an overview of the prevalence of hospital policies and practices. While data on hospital policies are fairly comprehensive, data on actual practices are limited. Available evidence suggests gaps exist between stated hospital policies and their actual practices, as well as between evidence-based strategies for addressing medical debt and current practice.

Financial Assistance

Hospital Policies

The Lown Institute has compiled comprehensive national data on hospital policies, outlining the prevalence of hospital financial assistance policies, including their accessibility, coverage, and restrictions (Table 5).[23] Most hospitals make their financial assistance policies available online (84%), including nearly all private nonprofit hospitals (99%), over half of public hospitals (57%), and about half of for-profit hospitals (49%). Among these, policies were offered in multiple languages by 75% of private nonprofits, 43% of public hospitals, and 74% of for-profit hospitals.

Most hospitals provide free (87%) and discounted (83%) care as part of their policies, although eligibility criteria vary widely. Eligibility for free care ranges from those with income levels under 150% of federal guidelines[b] to those making over 400%, with the most common threshold being 200%—about $50,000 for a family of three. Thresholds for discounted care range from incomes under 250% of federal guidelines to over 600%, with most setting thresholds at 400%—around $100,000 for a family of three. Even within the same city, eligibility thresholds may differ considerably, and close to half of hospitals (42%) require that patients must live within the state or a local area. Other restrictions may also be imposed, such as excluding insured patients or certain health care services.

[b] Federal guidelines refers to income eligibility based on federal poverty guidelines or federal poverty levels.

Table 5: **Prevalence of Hospital Financial Assistance Policies**

Policy Accessibility	
Hospitals with financial assistance policies available online	84%
Types of Coverage	
Hospitals offering free care	87%
Hospitals offering discounted care	83%
Policy Restrictions	
Hospitals limiting financial assistance to in-state or local residents	42%
Hospitals limiting free care to uninsured patients	14%
Categories of care commonly excluded from financial assistance policies	Infertility, bariatric, dental, ambulance, cardiac rehabilitation, transplant, and some physician services

Source: Lown Institute. Hospital Financial Assistance and Debt Collection Policies: A National Dataset, 2025.

Hospital Practices

Another area that provides insight into hospital efforts related to medical debt mitigation comes from hospital reporting on their total provision of financial assistance. Data compiled by KFF show that financial assistance spending (measured as a percentage of hospital operating expenses) varies considerably across hospitals, ranging from 1% or less to 7% or more—with 45% of hospitals at the lower end.[24] An overview of hospital spending on financial assistance is provided below (Table 6).

Table 6. **Levels of Financial Assistance Spending Across Hospitals**

Levels of Financial Assistance Spending	Percentage of Hospitals
1% or less of hospital operating expenses	45%
1-2% of hospital operating expenses	21%
2-3% of hospital operating expenses	10%
3-4% of hospital operating expenses	6%
4-5% of hospital operating expenses	4%
5-6% of hospital operating expenses	4%
6-7% of hospital operating expenses	2%
7% or more of hospital operating expenses	7%

Source: Zachary Levinson, Scott Hulver, Jamie Godwin, and Tricia Neuman, Key Facts About Hospitals (KFF, February 2025). Note: 2023 data.

Billing and Collection

Hospital Policies

In addition to their work on financial assistance policies, the Lown Institute also provides data on hospital policies for medical debt collection, outlining the proportion of hospitals that allow for ECAs to be taken against patients.[23] The data indicate that a majority of hospitals (59%) permit at least one kind of ECA, while only a small minority (4%) do not permit any.The remaining 37% do not specify. A breakdown of hospital ECA policies is in Table 7.

Table 7: **Percentage of Hospital Policies Allowing Extraordinary Collection Actions**

Extraordinary Collections Action	Policy Allows	Policy Does Not Allow	Policy Does Not Specify
Reporting debt to credit agencies	42%	15%	43%
Selling debt to third parties	19%	12%	69%
Denying non-emergency care	14%	12%	74%
Taking legal action	51%	10%	39%
Lawsuits	33%	14%	53%
Wage garnishment	30%	14%	56%
Property liens	38%	15%	47%

Source: Lown Institute. Hospital Financial Assistance and Debt Collection Policies: A National Dataset, 2025.

Hospital Practices

Evidence on hospitals' actual debt collection practices is limited and fragmented. While available data provide some indication of the extent of hospital actions to pursue patient debt, understanding the full scope of hospital debt collection practices is complicated by inconsistencies and gaps in national data.

The Leapfrog Group has assessed billing quality measures across hospitals and found substantial variation in billing practices.[25] In their 2022 national hospital survey with 2,270 respondents, one-third (33%) of hospitals reported taking legal action against patients for late or insufficient payments. Nearly half (45%) did not routinely send patients itemized bills in a timely manner (within 30 days). The overwhelming majority (96%), however, did provide instructions for contacting a billing representative who could investigate errors, negotiate price adjustments, or establish a payment plan. Overall, 62% of hospitals did not meet all three billing quality standards, underscoring widespread gaps in fair and transparent billing practices.

In another dataset, the Urban Institute's 2022 Health Reform Monitoring Survey, a nationally representative survey of adults, shows the percentage of adults with past-due hospital bills who experienced hospital actions to facilitate payment (Table 8) or to collect on medical debt (Table 9).[70] One in three adults with past-due hospital bills (36%) reported being offered payment plans, and one in five (22%) reported being offered discounts. However, the degree of financial protection that these payment plans provide is uncertain, as some options may include medical credit cards with high interest rates.[70]

Table 8. **Hospital Efforts to Facilitate Bill Payment**

Share of Adults with Past-Due Bills Reporting Hospital Efforts to Facilitate Payment	
Payment plan	36%
Discounted care	22%
Offered help with applying for Medicaid	6%
Sample size (adults with any debt owed to a hospital)	1,192

Source: Michael Karpman, Most Adults with Past-Due Medical Debt Owe Money to Hospitals (Urban Institute, 2023)

The most common debt collection action was contact by a collection agency, as reported by nearly two-thirds of adults with past-due bills (61%). Far fewer reported actions such as lawsuits or wage garnishment.[70]

Table 9. **Hospital Efforts to Collect Payment**

Share of Adults with Past-Due Bills Reporting Hospital Efforts to Collect Payment	
Collection agency contact	61%
Lawsuit filed	5%
Wages garnished	4%
Funds seized from a bank account	2%
Sample size (adults with any debt owed to a hospital)	1,192

Source: Michael Karpman, Most Adults with Past-Due Medical Debt Owe Money to Hospitals (Urban Institute, 2023).

State Regulations Addressing Hospital Policies

State governments play a critical role in shaping the provision of financial assistance and how medical debt is incurred, collected, and reported—often filling the gaps left by limited federal oversight. Still, as outlined in a 2025 Commonwealth Fund report, fewer than half of states currently set a minimum amount for how much financial assistance hospitals should provide and to whom.[5] States with stronger patient protections or more active hospital

oversight, such as Maryland, New York, and North Carolina, tend to impose clear financial assistance standards and limits on aggressive collections. Others defer entirely to the federal baseline, which only applies to nonprofit hospitals, adding to the already wide discrepancies in how patients experience medical debt depending on where they live.

The uneven landscape of state policies that influence patients' vulnerability to medical debt is illustrated below (Table 10). Even for states that regulate debt collection, there is considerable variability in the kinds of protections offered, with some states placing limits on certain ECAs and others prohibiting them outright.

Table 10: **Number of States with Regulations for Medical Debt Mitigation and Collection**

Financial Assistance Requirements	Number of States
Requirements for minimum eligibility and coverage rules	20 + DC
Medical Debt Protections	
Limits on credit reporting of medical debt	19
Limits for interest on medical debt	13
Regulating sale of medical debt to third parties	13
Strengthening wage-garnishment protections	35 + DC
Limits on liens or foreclosures	19 + DC
Reporting Requirements	
Requirements for hospitals to report on financial data, including total dollar amounts spent on financial assistance and/or bad debt	31 + DC
Requirements for hospitals to report on financial assistance program data, including numbers of applications received, approved, denied, and appealed	12
Requirements for hospitals to report on the above financial and application data by demographics, e.g., race, ethnicity, gender, preferred or primary language	6

Source: Maanasa Kona and Vrudhi Raimugia, State Protections Against Medical Debt: A Look at Policies Across the U.S. in 2025 (Commonwealth Fund, July 2025).

Priorities for Learning and Action

While available data and evidence provide valuable insights into hospital policies and practices around medical debt, considerable gaps remain. Addressing medical debt at scale will require both strengthening the evidence base and advancing effective strategies that are already within reach. This section discusses: 1) gaps in what we know about the extent of medical debt and how to address it; and 2) areas where we do have evidence about effective strategies, but gaps in practice and implementation.

What We Need to Know: Key Evidence Gaps

Understanding the full scope of medical debt requires more comprehensive and standardized data across several sources, including hospitals, credit reporting agencies, courts, and state-level data collection. Significant gaps remain in estimates of the prevalence of medical debt, hospital reporting practices, financial transparency, and evaluations of existing interventions. Table 11 below highlights areas where additional or improved data are needed to accurately assess medical debt burdens and inform more effective programmatic and policy solutions, as informed by the key informant interview portion of the environmental scan. References are noted where commentaries from the peer-reviewed literature provided additional support, along with other relevant sources of promising data and approaches.

Table 11. **Summary of Gaps in Data and Evidence**

Key Points from Interviews and Other Relevant Sources[c]		
Topic	**What is Missing**	**Why it Matters**
Population-Level Data		
Prevalence of Medical Debt	The full extent of medical debt remains unclear, as medical debt takes many forms and is inconsistently measured, with most surveys capturing only partial indicators[1]	Hinders comprehensive analysis of the true scope, socioeconomic distribution, and full financial impact of medical debt on patients
Credit Reporting	Credit data are largely proprietary and held by private credit bureaus, creating high administrative barriers and costs to researchers	
Court Records on Medical Debt	Medical debt litigation data are difficult to compile given inconsistent digitization and unclear identification of originating providers[71,72]	
Credit Card Data	Extent of medical debt that exists on credit cards to pay medical bills, which is technically considered financial debt	
Hospital-Level Data		
Financial Assistance Applications	Hospitals do not routinely report on the number of financial assistance applications attempted, completed, and approved, including patient demographics (income, race/ethnicity), although some states have started to require reporting on these data	Impedes a full understanding of hospital activities regarding financial assistance and debt collection, and the affected patient populations
Debt Collection Practices	Hospitals do not routinely report on the number of patients with unpaid bills, the debt size, insurance status, and the number of ECAs, including patient demographics (income, race/ethnicity[c]	

Hospital Financial Transparency	Despite IRS and other reporting requirements, there is limited hospital financial transparency, such as information on assets, reserves, and profits, and there is lack of consensus about which data would be most meaningful to track	Limited transparency of hospital financial data makes it difficult to understand the varied capacities and needs of different hospitals and how to best ensure hospital sustainability while also being able to meet the needs of their patient populations
Hospital Operational Expenses and Revenue	Given the complexity of hospital financial administrative processes, there is limited insight into distributions of hospital revenue (e.g., what percentage of health care revenue goes to the hospital vs physicians vs third parties)	
Return on Investment of ECAs	While available data suggest limited benefit to pursuing ECAs, rigorous research is needed to assess the return on investment of various debt collection practices and whether this varies across hospital types[26,27]	Without a clear understanding of the overall costs vs benefits of ECAs, implementing the most effective debt mitigation strategies can be challenging
Landscape of Financial Tools	There is a lack of transparency of the vendors and products (e.g., presumptive eligibility tools, revenue cycle management companies, medical credit cards) that hospitals are using, and their market share	Lack of information about the different products in use limits understanding of what benefits are accruing to whom, along with any associated adverse consequences
Research/Evaluation Studies		
State Policies	Variations in enforcement, implementation, and consumer awareness make it difficult to evaluate state policy protections[68,73,74]	Limits understanding of how different policies affect patients, hospitals, communities, and even local economies, including making the business case for reform
Programmatic Interventions	Rigorous evaluations are needed to assess different programs for addressing medical debt, e.g., financial navigation programs	Effectiveness of different medical debt interventions and their impacts on patients and families is unclear
Business Case for Underfunded Health Services	Rigorous evidence quantifying the economic and broader societal value of health care services, such as preventive care and palliative care	Health care services that have the potential to curb avoidable procedures, improve patient wellbeing, and provide cost savings remain underfunded

[c] References are noted where commentaries from the peer-reviewed literature provided additional support to the key informant interviews, along with other relevant sources of promising data and approaches.

What We Can Do Now: Effective and Promising Approaches

Decision makers do not need to wait for the conclusion of further research to take meaningful action. Our environmental scan revealed valuable insights into opportunities for reducing medical debt through both proven and innovative approaches and policy levers that could drive more consistent and equitable hospital policies and practices. Outlined below are approaches that rely upon strategies supported by the peer-reviewed literature as well as promising approaches that emerged from the key informant interviews. Where commentaries from the peer-reviewed literature provided additional support, references are noted.

Approaches that Hospitals Can Lead

1. Patient-Centered Financial Assistance and Other Programs

Reducing medical debt begins with providing financial assistance and other relevant support to assist patients with affording the high costs of care.

Effective approaches include:

- Optimizing the provision of financial assistance to address both eligibility and access issues to ensure those in need of assistance are able to receive it
- Hospital participation in HPE programs to facilitate temporary Medicaid coverage for eligible patients, although recent and pending health policy changes may present a more complex environment for providing such coverage, along with serious implications for the privacy and security of patient Medicaid data
- As a supplement to providing direct financial assistance, ensuring dedicated staff support for patient education and guidance to manage costs of care, including assistance with applying for health insurance and medication assistance programs
- As appropriate, coordinating with care teams, including clinicians, to assist with navigating and addressing the costs of care

Promising approaches include:

- Using presumptive eligibility tools at intake to screen patients for financial assistance, removing burdensome paperwork requirements, streamlining workflows, and facilitating consistent access to aid—while also developing safeguards to provide transparency, ensuring appropriate privacy protections are in place and that tools are being utilized to verify hospital-established eligibility criteria as opposed to assessing patients' propensity to pay[75]

- Offering sliding-scale, zero-interest payment plans for patients who do not qualify for financial assistance, and avoiding predatory medical credit cards, which can further trap patients in high-interest debt[28]

2. Ethical Billing and Responsible Debt Collection
Prioritizing mission-aligned and patient-centered approaches is important so that financial operations reinforce, rather than conflict with, the institution's core purpose of promoting patient health, particularly given limited return on investment of aggressive collection practices.

Effective approaches include:

- Adopting ethical billing practices, including transparent communication of charges and access to a billing representative for questions, while avoiding aggressive collection tactics

Promising approaches include:

- Ensuring that patients who were not screened for financial assistance at the time of care, and who would have qualified, do not receive bills retroactively
- Charging self-pay patients rates that do not exceed those for patients covered by insurance[27]
- Engaging with all contracted entities, including revenue cycle vendors, physician groups, and others, to ensure that consistent billing ethics and socially responsible financial practices are in place

3. Organizational Leadership, Culture, and Decision-Making
Shifting organizational culture by working with a range of champions is central to achieving effective change.

Promising approaches include:

- As a counterpoint to the revenue cycle perspective, involving hospital leaders who consider the hospital's broader role and impacts in the community in financial decision-making
- As anchor institutions, addressing medical debt to improve population well-being and ensure financial resources remain in communities to benefit both patients and the institution
- Incorporating clinicians, the community health or community benefit department, hospital social workers, hospital boards, and patient and community representatives in determining and implementing hospital financial policies (e.g., financial assistance and debt collection)
- Engaging clinicians, in particular, as champions, as they can experience moral distress when learning about aggressive collection tactics, and could have a greater role in decision-making, but lack a collective voice and formal channels for influence within the system
- Considering trust as a unifying force as both hospital leaders and clinicians may experience and see a loss of trust with the increasing corporatization of health care, underscoring the importance of leaning into organizational values and ensuring they are reflected in financial policies (e.g., financial assistance and debt collection)

4. Partnerships with Community-Oriented Organizations
Collaborating with community and advocacy organizations presents a valuable opportunity for hospitals to leverage the expertise of community-oriented institutions to meet the needs of both patients and hospitals.

Promising approaches include:

- Partnering with patient- and community-centered organizations, such as Dollar For, Community Catalyst, and Undue Medical Debt that can streamline processes and offer support in such areas as navigating financial assistance, enhancing cultural sensitivity, and providing access to debt relief, respectively
- Exploring opportunities for investing in financial products developed under a more cooperative and patient-centered model focused on public benefit, such as billing services that provide support for achieving administrative efficiencies without engaging in predatory practices

Approaches That Require Broader, External Leadership

5. Engaging Policy, Industry, and Public Support
At the policy level, state legislation offers critical protections, particularly in the current environment, although federal protections are also needed. In addition, media and public engagement offer a crucial means for coalescing broad support.

Effective approaches include:

- Establishing state requirements for financial assistance reporting and/or minimum financial assistance spending for more equitable access, along with medical debt protections and reporting

- Maintaining mandatory state or voluntary industry billing standards
- Drawing wider media and public attention to medical debt and the impacts of aggressive debt collection practices

Promising approaches include:

- Establishing policies at the federal and/or state level to improve access to financial assistance, such as minimizing application and documentation requirements, and ensuring that nonprofit hospitals' financial assistance spending is at least equivalent to the value of tax benefits being received[29,30]
- Prohibiting the use of ECAs, as some states have started to do, including banning credit reporting, as these actions have disproportionately harmful consequences on people's lives
- Highlighting model financial assistance policies that hospitals could adopt or adapt, as they try to identify successful efforts
- Developing a list of vendors vetted at the state or federal level, for example for financial navigation services or revenue cycle management companies, to provide an objective reference of entities that have the requisite skills/capacity and engage in socially responsible practices
- Holding insurers accountable for plan design, insurance that is affordable, and pre-enrollment patient education to ensure patients have a clear understanding of their coverage[3]
- Highlighting narratives as powerful tools for engaging the public and influencing decisionmakers, as many people may not know how common medical debt is or the types of ECAs that are legally allowed and their impacts—even credit reporting can be devastating for people's lives, affecting their ability to obtain employment or housing, which only further jeopardizes their ability to pay

Conclusion

Health care prices and costs continue to rise, diminishing trust in the institutions that are supposed to take care of us when we are most vulnerable. Both medical debt and the prohibitively costly care that contributes to it need to be remedied. Amidst ongoing policy debates about health care financing, health services researchers, health system leaders, and other partners can take important steps now to rebuild trust and focus on an issue that impacts so many.

Hospitals can play an important role in leading this effort, first, by adopting patient-centered financial assistance and ethical billing practices. The current health policy landscape presents considerable challenges for hospitals, as they address their own financial sustainability. By working with other partners, such as patient and community groups, physicians, researchers, insurance companies, and policymakers, there is an opportunity to design solutions that consider the needs of all involved. A multifaceted approach that integrates patient-centered practices, evidence-based strategies, organizational and culture change, and policy standardization will be important. This moment calls for collective action, bringing all who are affected to the table to develop an attainable, just, and equitable approach to address the growing burden of medical debt. In the second year of this project, we aim to learn more from hospitals and other key partners to support the adoption of ethical medical debt policies and practices.

Appendix A: Methods Details

Literature Review

A search strategy was developed for the peer-reviewed literature in PubMed, along with eligibility criteria for article inclusion, based on prior literature and guidance from the scholars in residence. The following search string was used: ((“medical debt*” OR “debt collect*” OR “extraordinary collect*” OR “patient debt*” OR “credit report*” OR “bad debt*” OR “presumptive eligibility” OR “charity care” OR “financial assistance program*” OR “payment plan*” OR “insurance verification*” OR “debt forgiv*”) AND (English[lang])). Eligibility criteria included articles published between January 1, 2020 and March 4, 2025, articles focused on the U.S. health care system, and articles that were explicitly focused on health system policies or practices related to medical debt mitigation or debt collection.

The search was conducted on March 4, 2025 and yielded 312 PubMed results. Title, abstract, and full text reviews were conducted for relevance based on the inclusion and exclusion criteria. A single reviewer (MK) conducted an initial title review, and any articles in question were reviewed by a second reviewer (EC) and then collectively resolved. A subsequent abstract review for relevance was conducted by two reviewers (TD and MK). Differences were resolved by discussion and consensus, and any articles in question were reviewed by a third reviewer (EC) and collectively resolved. Finally, a full text review was conducted by two reviewers (TD and MK). Differences were resolved by discussion and consensus, resulting in 73 articles, 20 of which were commentaries, and thus not included in the analysis, resulting in 53 research studies for analysis.

Search Results

PubMed	Number
Initial Set of Records Identified	312
Results from Title Review	256
Results from Abstract Review	116
Results from Full Text Review	73
Results for Inclusion in Analysis (excluding commentaries)	53

Utilizing a spreadsheet for data extraction and coding, research studies were coded according to the following categories: medical debt mitigation strategies, medical debt collection strategies, associated outcomes, facilitating factors, barriers, study methodology, care setting, and geography.

The extracted data were analyzed to identify common and salient themes across the literature. Additional resources were subsequently identified to address gaps in the initial search, by handsearching the grey and peer-reviewed literature.

Key Informant Interviews

The key informant interviews addressed the following areas:

- landscape around medical debt, particularly as it relates to hospital policies and practices;
- opportunities for enhancing the role of hospitals in addressing medical debt;
- effective hospital-led efforts in preventing or mitigating medical debt;
- key hospital decision makers are who are typically involved in discussions around medical debt, as well as others who could have a role to play;
- third parties or programs that would be helpful for hospitals to partner with;
- ongoing or new barriers for hospitals in addressing medical debt;
- and evidence gaps that need to be filled.

Interviews were conducted by the project team, including the scholars in residence. Each interview included the interviewer (EC, KC, or ES), a notetaker (TD or MK), and the key informant. All interviews were conducted virtually, via Zoom, to allow for maximum participation. Each interview lasted approximately 45 minutes. To ensure accurate documentation, all interviews were recorded with permission from the interviewee. All interviewees were informed that their comments would remain anonymous and be used only to inform the environmental scan. Each interviewee was offered an honorarium of $150. Following completion of the interviews, AcademyHealth staff (TD and MK) compiled and reviewed all interview notes to identify key themes across the interviews, identifying both where the interviews affirmed the literature review findings and where new ideas were raised, addressing gaps in the literature and highlighting areas for further exploration.

The research studies from the peer-reviewed literature informed the evidence base for effective hospital strategies for addressing medical debt. The key informant interviews reinforced many of the findings, while also raising new insights focused on broader system level factors. Resources from grey literature served to inform the prevalence of hospital policies and practices, while the peer-reviewed literature and key informant interviews informed the gaps and promising approaches, supported by commentaries where applicable.

Appendix B: Evidence on Hospital Strategies Detailed Tables

Mitigating Medical Debt

Strategy	Associated Outcomes	Implementation Enablers/ Reinforcing Factors	Implementation Barriers/ Restraining Forces
Financial Assistance Hospitals provide financial assistance in the form of free or discounted care, also known as charity care, to eligible patients. Non-profit hospitals are required under federal law to meet a community benefit standard, which includes financial assistance, to maintain their tax-exempt status. Additionally, nonprofit hospitals are required under the ACA to create and widely publicize their financial assistance policy.[76]	Increased patient health care utilization, including high-value care[6,50] Patient cost savings[6] Improved patient health outcomes[6] Higher hospital eligibility limits for financial assistance[48,77] Increased hospital financial assistance spending[46,47,77]	State requirements for minimum community benefits[47,48] State requirements focused specifically on financial assistance reporting as opposed to broader community benefit reporting[46] Programs focused on specific health care conditions and featuring clinician support[6,49]	Vague language in hospital policies[61,78,79] Wide variation in eligibility criteria and documentation requirements[61,62] Limited patient awareness of financial assistance availability and eligibility, and fear of potential impacts on care[60] Complex and burdensome application and documentation processes[59-61] Limited federal requirements regarding levels of financial assistance provision[20,21,80] Varied levels of financial assistance spending across hospitals, including misalignment with such factors as tax benefits and financial performance[18-22]
Hospital Presumptive Eligibility (HPE) Program Allows hospitals to provide individuals likely to be eligible for Medicaid with temporary coverage (up to about two months) with the potential for ongoing coverage.[81] All states are required to operate an HPE program under the ACA, however, there is no requirement that hospitals participate in the given program.[52]	Temporary Medicaid coverage for patients[82,83] Patient sustainment of Medicaid coverage at six months[84,85] Increased net Medicaid revenue and reduced uncompensated care costs for hospitals[51,52]	Dedicated staff support and collaboration, availability of interpreters, and third-party vendors for application and follow-up support[56] Policy changes during COVID, including state expansion in HPE eligibility and remote approval via telephone/video, while also acknowledging value of in-person contract for trust[82] Perceived benefits by hospital leadership and stakeholders: reduced hospital bad debt, improved patient satisfaction and care access, avoiding lost resources and time collecting from patients with low likelihood of payment[51]	Multi-phase and complex application process.[56] Insufficient staffing for patient screening and application submission[51,56,82,83] Technical and access barriers with online state HPE portal for hospital staff[51,56] Patient knowledge gaps about insurance acquisition, and fear of disclosing personal information, e.g., regarding finances or immigration status[51,56] Difficulty making contact with patients once they leave the hospital[56,82,83] State-level variation in HPE eligibility and coverage groups[86]

Strategy	Associated Outcomes	Implementation Enablers/ Reinforcing Factors	Implementation Barriers/ Restraining Forces
Financial Navigation Services Often offered in the context of cancer programs, these services provide support for patients, families, and caregivers to overcome financial barriers through such means as application support for financial assistance, pharmaceutical assistance, and insurance; direct financial support with medical and nonmedical costs; and understanding the financial aspects of their care, including budgeting and insurance benefits.[53]	Increased patient knowledge of financial resources[7] Patient psychosocial benefits (reduced anxiety)[7] Patient cost savings[7,8] Reduced medical debt write-offs and savings on financial assistance spending for hospitals[7]	Educational support for patients[7,53] Interdisciplinary communication among health care team[7,57] Financial toxicity EMR order set improving clinical workflow and connecting patients directly to hospital financial counseling and assistance[8] Staff support in applying for varied assistance from foundations and pharmaceutical companies, and applying for health insurance, including outsourcing insurance application assistance to external organizations[53,57] Direct financial support for patient health care costs[7]	Patient hesitancy in admitting financial needs; limited patient understanding of out-of-pocket costs and managing costs of care[57] Limited dedicated, trained financial navigators[53,57,87] Clinician and staff hesitancy to engage in cost-of-care conversations; challenges in providing cost estimates because of limitations in accessing information about health insurance coverage and cancer treatment costs[53,57] Limited institutional budget, lack of reimbursement for services, clinical time constraints[87]
Medication-Focused Assistance Programs Financial assistance programs that are focused on providing support for prescription medications, often via sources such as foundations, pharmaceutical companies, and federal and state government programs.[88]	Patient access to care (medications)[9-11] Increased medication adherence among patients[12,54] Reduced health care utilization (surgery) among patients[11] Improved patient health outcomes[12] Patient cost savings[9,10,13] Increased hospital financial assistance spending (offset by other community benefit spending)[67]	Dedicated support from specialized staff (e.g., pharmacy and other health care staff with potential coordination with clinicians) to assist patients with enrollment[9,10,58] Within COVID context, clinicians suggesting inexpensive medications and supplies, offering samples, helping apply for drug assistance[89] Longer-term assistance for medication access (one year vs one month), on-site pharmacy fills before patient leaves the hospital[54] Hospital participation in 340 B program[9,67]	Limited scope of formulary[9] Hesitation in sharing personal financial information[58]
Payment Plans Options for patients to pay for health care services over time for non-emergent care.[55]	N/A	Broad availability of payment plans by hospitals, and in some cases, their third-party vendors[55,87]	Lack of centralized financial and application services[55] Variation in payment plan structure, eligibility criteria, payment timeframes, applicable fees, upfront payment requirements, and interest accrual[55]

Addressing Medical Debt Through Ethical Billing Practices

Strategy	Associated Outcomes	Implementation Enablers/ Reinforcing Factors	Implementation Barriers/ Restraining Forces
Ethical Billing Practices Practices may include providing patients with itemized billing, instructions for contacting a billing representative, and not taking legal action against patients for late or insufficient payment[14]	Decrease in ECAs, i.e., credit reporting, lawsuits, wage garnishments, and liens[15-17] Increase in levels of hospital bad debt/ medical debt write-off[68] Financial relief, bill corrections, payment plan and/or better understanding of bill for patients[69]	Greater public attention and scrutiny regarding aggressive debt collection practices[17] Industry standards for hospital billing quality[25] State legislation expanding medical debt protections[68] At individual level, patient self-advocacy[69]	Limited support and guidance for patients regarding medical debt management and legal protections[53] Variation in billing and collection practices across hospitals[15,16,25] A minority of large hospitals being responsible for the majority of litigation[16] Views among some hospitals that reporting medical debt to credit agencies and selling debt to third parties should not be considered ECAs, and that hospitals should not be held liable for third-party actions[90] Lower total hospital revenue[15]

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