As described below, hospital debt poses a significant problem for millions of Americans. This article provides a nine step approach for lower-income patients seeking to eliminate or reduce hospital debt.

**Medical Debt Is a Widespread and Serious Problem**

More than 27 million Americans lack any health insurance—58% of low-income working adults, 44% of young adults, and 35% of Latinx adults. In addition, almost 50% of nonelderly adults have insurance that requires high deductibles and significant out-of-pocket costs. In recent years the number of Americans uninsured or underinsured has been growing.

As a result, a high number of families are burdened with medical debt:

- 20% of uninsured adults went without needed medical care in 2018 because of the cost;
- 59% of people contacted by a debt collector said it was over a medical debt;
- 20% of Americans have at least one medical debt collection item on their credit reports and 58% of debt collection accounts reported on credit reports are for medical debt;
- 66% of all bankruptcies were tied to the cost of medical care or time lost from work due to an illness or injury.


As a result, there is an urgent need to address consumers’ medical debt problems. A detailed discussion is found in NCLC’s *Collection Actions Chapter 9* [2]. This article provides a nine step approach for lower-income Americans to reduce or avoid their hospital bills.

**Step 1: Don’t Prematurely Pay Even Part of the Hospital Bill**

Depending on the state and the patient’s income, the bill may be waived in whole or significantly reduced—there is no benefit in making payments that may not be owed. Nor is there any downside in delaying payment:

- The major credit reporting agencies (Equifax, Experian, and TransUnion) have agreed pursuant to a nationwide attorney general enforcement action not to report negative information about medical bills for 180 days.
- State actions may provide other limits on credit reporting of hospital debt. Minnesota hospitals and their debt collectors cannot report a patient to a credit reporting agency for any patient’s failure to pay a medical bill. Maine prohibits credit bureaus from reporting medical debt on a credit report for 180 days after the first delinquency. Washington prohibits collection agencies from reporting medical debt to credit bureaus until at least 180 days after the collection agency receives the debt for collection or by assignment. See generally NCLC’s *Don’t Add Insult to Injury: Medical Debt & Credit Reports* [3] (Nov. 2019).
- Bills are unlikely to be immediately sent out to a collection agency, and if that happens a simple letter from the patient or the patient’s attorney often will stop the collection contacts. See NCLC’s *Fair Debt Collection § 5.10* [4].
- By federal law, a hospital cannot deny a patient emergency room services because of unpaid hospital bills. See NCLC’s *Collection Actions § 9.3.3* [5] Nonprofit hospitals cannot deny any form of care for at least 120 days after the hospital bill is sent. See NCLC’s *Collection Actions § 9.3.1.5.2* [6]. Nor is the hospital likely to deny the consumer other services for at least a short period after the bill remains unpaid.

Thus the first step in dealing with debt from a nonprofit hospital is delaying any payment on the hospital bill until a determination is made whether the patient qualifies for financial assistance that will lower or eliminate the bill. This includes never putting the hospital bill on a credit card. A card company will charge interest on amounts that the consumer might not ever have to pay. Putting the bill on a credit card is never a good idea because the patient loses the ability to negotiate for lower amounts, either due to financial assistance policies or because the bill is for “chargemaster” prices, which are often several times what insurance companies or Medicare/Medicaid pay. Also, a hospital almost certainly will charge less interest and be more forgiving than a credit card issuer.

**Step 2: Determine If the Consumer Is Medicaid Eligible**
Determine if the patient is Medicaid eligible. In some but not all states Medicaid coverage is retroactive to hospital bills incurred over the prior three months. Even where a state does not allow retroactive coverage, if the patient is found to be Medicaid eligible then at least for future bills they will have that source of payment for any follow-up treatment or other conditions.

Apply for Medicaid by going to www.healthcare.gov or calling 800-318-2596, or at the local public assistance office. Eligibility for Medicaid varies from state to state and depends on family income and may also depend on family resources. Some states limit Medicaid to certain groups of people, such as children and pregnant women. However, people in many states automatically qualify so long as their income is 138% of the poverty line or below. (In 2020 the income limits are: $17,236 for a family of one; $23,336 for a family of two; $29,435 for a family of three; and $6,100 for each additional family member. The poverty line is higher in Alaska and Hawaii.)

Sometimes children are eligible for Medicaid even if their parent is not. Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements mandate coverage of a broad array of diagnostic, preventive, and treatment services for beneficiaries under age 21.

In addition to Medicaid, some states may offer other programs to help lower-income patients with healthcare bills. Ask the hospital financial counselor or patient advocacy organizations in your state for more information.

**Step 3: Determine If a Hospital Is a Nonprofit**

As described below, a consumer has additional federal rights concerning a hospital bill if the hospital is a nonprofit 501(c)(3) entity, and additional state law rights may apply as well in a few states. To determine if a hospital is a nonprofit, go to the [IRS website](https://www.irs.gov) [7]. In particular, go to the [IRS tax exempt organization search page](https://www.irs.gov) [8] and search by organization name (under the drop down starting with employment identification number). The website will only identify if a hospital is a 501(c)(3) entity. If the hospital is not found, it may be that it is still nonprofit but under a different name (such as hospital’s parent entity) or the name has not been included in this database.

It is always wise to check to see if a hospital is a nonprofit even if it does not show up on the above website. Alternative methods of determining if a hospital is nonprofit include checking the hospital’s website, asking a hospital administrator, or talking to the hospital’s billing office.

**Step 4: If the Hospital Is a Nonprofit, Understand Consumer Rights Under Federal Law**

The Affordable Care Act (ACA) (also known as Obamacare) imposes certain requirements on nonprofit hospitals with 501(c)(3) IRS tax status concerning their financial assistance policies for low-income patients. Hospitals must create a written financial assistance policy (FAP) and a written emergency medical care policy. The financial assistance policy must disclose:

- The eligibility criteria established by the hospital for receiving financial assistance and whether such assistance includes free or discounted care;
- The basis used to calculate how much patients are charged for care;
- A description of the methods for applying for financial assistance;
- If applicable, any information other than that supplied by the patient used by the hospital to determine financial assistance eligibility, including prior determinations of eligibility; and
- A list that shows which of the hospital’s doctors and health care providers are covered by the financial assistance policy and which are not covered.

Federal law does not require hospitals to offer any special level of financial assistance and does not specify who is eligible for financial assistance. Federal law only requires that nonprofit hospitals have a written policy and that this policy and the method for applying for assistance be disclosed.

**Step 5: Whether the Hospital Is Nonprofit or For-Profit, Understand Rights Under State Law**
Unlike federal law, state laws often specify standards for how much financial assistance a hospital must provide a patient of a given income level, and these state laws typically apply both to for-profit and nonprofit hospitals. But applicable state law varies significantly from state to state.

For example, ten states have enacted laws that require hospitals to provide a full spectrum of free and discount care for patients under specific eligibility standards, primarily based on income: California, Connecticut, Illinois, Maine, New Jersey, New York, Nevada, Rhode Island, Washington, and Maryland. On the other hand, five states (Hawaii, Montana, New Hampshire, Wisconsin, and Wyoming) have no financial assistance requirements. The other thirty-five states are somewhere in between.

Even among the ten states that have strong protections, there are differences. In Maine, all hospitals must provide free care for patients whose household income is up to 150% of the federal poverty level (FPL), but there is no discount care at all for those with higher incomes. Illinois on the other hand requires all hospitals to provide free care for those who are uninsured with family income of up to 200% of the FPL or up to 125% FPL for rural or critical access hospitals. But Illinois also mandates discount care for those with family income of up to 600% of FPL.

A number of states provide requirements only for nonprofit or state hospitals (Oregon, Texas, and Louisiana). Some states provide assistance directly from the state for hospital bills (Massachusetts, Colorado, and South Carolina). There are even more variations in other states.

Detailed state-by-state summaries of financial assistance requirements are available from two NCLC resources: NCLC’s An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States [1] (Jan. 2020) and NCLC’s Collection Actions § 9.4.3 [9]. An Ounce of Prevention includes eight appendices summarizing each jurisdiction’s type of financial assistance as well as who is eligible, the source of funding for the plans, and the statutes (if any) that mandate the assistance, which allows advocates and legislators to compare their state with the policies in other states.

NCLC’s Model Medical Debt Protection Act [10] (Sept. 2019) provides language for a model state law mandating financial assistance for lower-income hospital patients. The model act specifies eligibility guidelines for financial assistance, provides specific guidelines for charity and discounted care, and includes procedural safeguards to protect consumers from aggressive or unfair debt collection practices.

A growing number of states have also enacted “surprise” medical debt legislation—at present about half the states have this legislation. Surprise medical debt laws limit bills from out-of-network physicians providing services at an in-network hospital. These laws address the situation in which a patient assumes their insurance covers care at an in-network hospital only to be surprised that an individual doctor’s bill at the hospital is not covered by insurance. There are also some state laws dealing with balance billing—where a hospital agrees to receive less than the full chargemaster price from the insurance company and then bills the patient for the difference. See NCLC’s Collection Actions § 9.4.3.1 [11].

Step 6: Obtain the Hospital's Financial Assistance Policy

It should not be difficult to obtain a hospital’s financial assistance policy (FAP). For nonprofit hospitals, federal law requires hospitals to:

- Provide the FAP, a plain language summary of the FAP, and the FAP application on the hospital’s website and, upon request, by mail and in public locations including the hospital’s emergency room and admission area;
- Offer paper copies of the FAP’s plain language summary as part of the intake or discharge process;
- Set up conspicuous public displays that notify patients about the FAP, including at a minimum, in the hospital’s emergency room and admission area;
- Include a conspicuous written notice on billing statements that alerts and informs patients about the availability of financial assistance under the hospital’s FAP, the telephone number of the hospital department that can provide information on the FAP and application process, and the website where copies of the FAP can be obtained;
- For certain communities, hospitals must provide written translations of the FAP, the plain language summary, and the FAP application into the primary language spoken by that limited-English-proficiency population.

The above requirements apply to nonprofit hospitals, but for-profit hospitals may use some of the same methods to publicize their policies. If all else fails, ask the billing office for a copy of any financial assistance policy.
**Step 7: Compare the Financial Assistance Policy with State Requirements and the Individual Patient’s Circumstances**

Many hospitals will have a financial assistance policy. Federal law requires every nonprofit hospital to have one, some states require all hospitals to have one, and even where a for-profit hospital is not required to have one by federal or state law, it may still voluntarily have such a policy. For example, Vermont hospitals have all voluntarily created financial assistance plans.

Compare the policy with any state requirements. In a shockingly large number of cases hospital financial assistance policies do not comply with state law. See [NCLC’s Collection Actions § 9.4.3.1][11]. Then compare the policy with the patient’s income and the type of care the patient received to see if the patient qualifies for assistance.

**Step 8: Applying for Financial Assistance**

After determining whether the patient’s income and family size qualify under the financial assistance policy, make sure that the hospital procedure is covered by the financial assistance policy. Some procedures such as cosmetic surgery may not be covered.

Next, find out how to apply for the assistance. The patient may have to provide a detailed budget, list of assets, information about family members, tax returns, or proof of income. Federal law requires nonprofit hospitals to explain in their financial assistance plan the procedure for applying for financial assistance. If the financial assistance plan does not fully explain the application process, call the hospital’s billing office for more information. Do not delay as many programs only give you about 240 days after the care or procedure to apply for assistance.

Federal law places certain requirements on a nonprofit hospital’s handling of an application for financial assistance, such as a denial cannot take place because of missing information not specified in the hospitals disclosure of application requirements. If a nonprofit hospital provides limited financial assistance without even reviewing an application for assistance, the patient still has the right to seek additional assistance. See generally [NCLC’s Collection Actions § 9.3.1.5.5][12].

**Step 9: If an Application for Financial Assistance Is Denied**

If a patient is denied assistance, some hospitals may have an appeals process. Pay attention to the time allowed for any appeal. There may be steps to preserve a claim for financial assistance.

If the patient ultimately does not qualify for assistance, some hospitals provide payment plans to pay off the debt over an extended period of time. But a patient should never agree to a payment plan that the patient cannot afford or that would prevent payment of other of the patient’s debts.

Hospital debt should be treated as a lower priority debt compared with rent, utility, mortgage and automobile loans, and most other forms of debt. Non-payment of that other debt will have serious immediate adverse consequences, while hospital debt may have little negative effect for six months (as described above) and it may be years, if ever, before a judgment is taken against the consumer for the debt. Also, hospital debt is unsecured debt that is fully dischargeable in bankruptcy.

When a judgment is taken against a patient, it will be important to determine the patient’s exposure to wage garnishment and seizure of bank accounts or other property. But some low-income patients may be totally judgment proof.

Be aware that under state necessaries statutes or common law doctrines a spouse may be liable for the other spouse’s treatment and a parent for children’s treatment. For more detail, see [NCLC’s Collection Actions § 9.6][13].

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Andrea Bopp Stark is a staff attorney focusing on fair debt collection practices, including criminal justice debt. She also teaches an Introduction to Consumer Rights Litigation practicum course at Boston College Law School. Andrea is a contributing author to NCLC’s [Fair Debt Collection] and [Mortgage Servicing and Loan Modifications] legal manuals. Previously, Andrea was a partner at Molleur Law Office in Biddeford, ME, and worked as an attorney for Northeast Legal Aid in Lawrence, Massachusetts where she was one of NCLC’s first recipients of the John G. Brooks fellowship. Andrea holds a B.A. from the University of Vermont and obtained her JD and Masters of Social Work from Boston College. She is admitted to...
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Source: National Consumer Law Center, [], updated at www.nclc.org/library
Source URL: https://library.nclc.org/guide-reducing-hospital-bills-lower-income-patients

Links
[4] https://library.nclc.org/nclc/link/FDC.05.10
[5] https://library.nclc.org/nclc/link/CA.09.03.03
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