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Author

Manzanilla, Alexis

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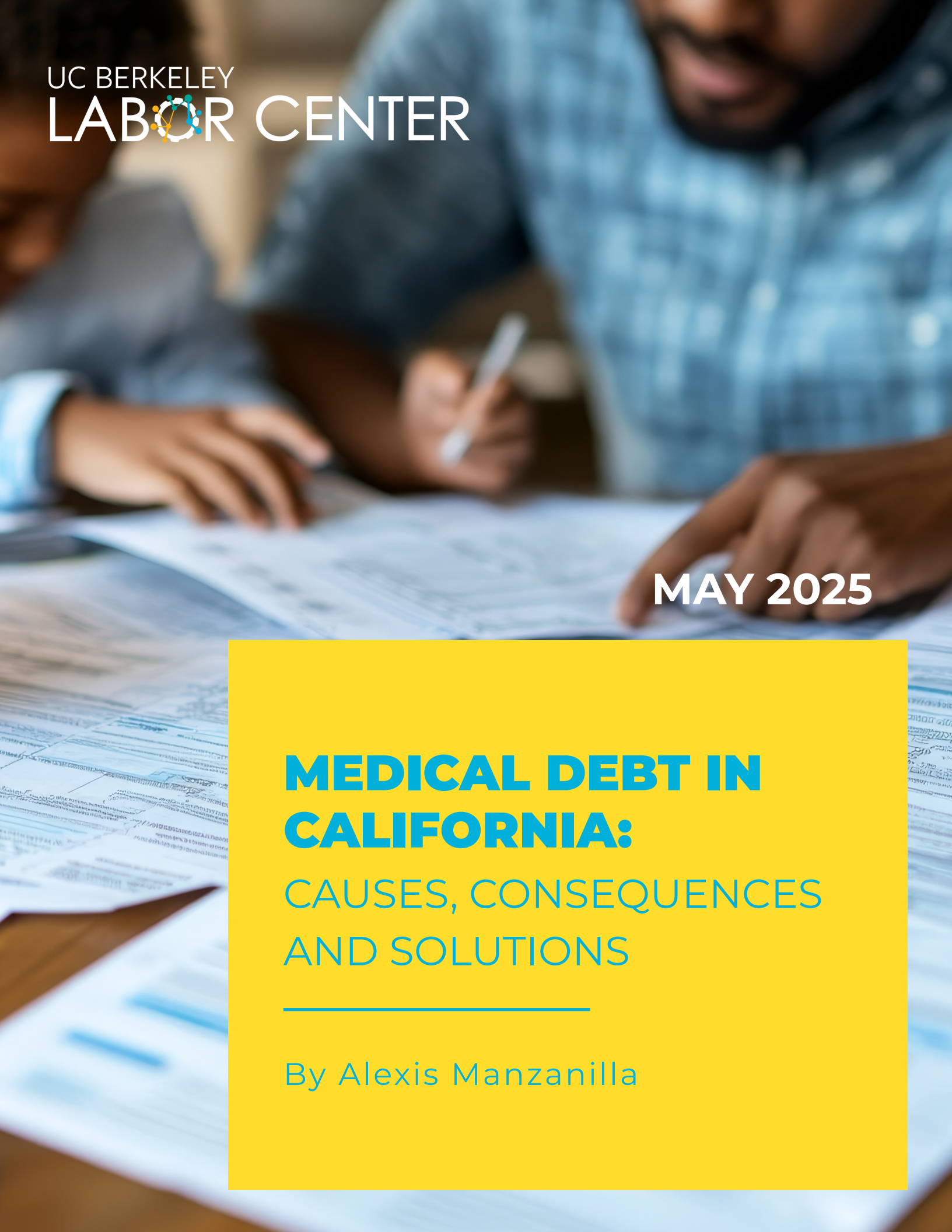

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MEDICAL DEBT IN CALIFORNIA:

CAUSES, CONSEQUENCES AND SOLUTIONS

By Alexis Manzanilla

Executive Summary

Medical debt is a pervasive problem in California, affecting both those with and without health insurance. While medical debt disproportionately impacts low-income communities and communities of color, in 2023, nearly four in ten of all Californians had this type of debt.

Common causes of medical debt include unexpected, emergency medical events, high out-of-pocket costs including premiums and deductibles, and errors in billing or financial assistance assessments.

Medical debt has significant impacts on consumers' financial and emotional well-being. In addition to the mental health toll, medical debt impairs consumers' ability to pay for other health care necessities and living expenses such as food and housing. It also erodes consumers' trust and motivation to pursue future medical care, and in some cases their ability to access care. Los Angeles County recently labeled medical debt a public health issue on par with diabetes and asthma.

Existing law in California aims to tackle the medical debt problem both by preventing or reducing it, and by mitigating its consequences. Recently enacted federal and state laws have increased access to medical financial assistance and have restricted medical debt from appearing on credit reports in order to reduce financial consequences of medical debt.

Protecting health care coverage through Medi-Cal and Covered California is critical to ensuring that medical debt problems do not get worse. Policymakers could also consider broad solutions like pursuing a single payer system and reining in health care prices, and more targeted solutions like improving access to hospital financial assistance programs and limiting aggressive billing and collections practices in health care.

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Introduction

Many Californians, including those with insurance, face challenges with health care affordability. Medical debt is a symptom of this problem. It harms consumers' health and significantly contributes to financial hardship. The most effective and straightforward way to eliminate the problem of medical debt would be to make health care more affordable. Short of this, federal and state legislation has been enacted with the objective of preventing and mitigating some of the consequences of medical debt.

This paper focuses on medical debt in California, and existing and potential policy solutions to ameliorate the ruinous financial effects of medical debt in the state. We review existing research, consumer surveys, news articles, and enacted and proposed legislation to identify and analyze the causes, effects, and possible solutions to the medical debt problem in California. While we focus on California, we include national data where state-specific information is unavailable.

Prevalence of medical debt

Four in ten Californians have medical debt

In 2023, nearly four in ten Californians (38%) reported having any kind of medical debt, and one third of this group owed $2,500 or more.[1] Common examples of medical debt include medical bill claims that are unpaid or sent to collections, as well as debt from using credit cards, payment plans, bank loans, or borrowing from family or friends to pay medical expenses.[2] Across income groups, the most commonly reported type of medical debt for Californians was through use of credit cards, and the least reported type was owing money to family and/or friends.[3]

Medical debt is the most common type of debt on consumer credit reports

A credit report includes a list of a consumer's allegedly past due debts for such things as car loans, student loans, and mortgages. Debt collectors may contact consumers to try to collect on past-due bills. The more outstanding unpaid debt a person has on their credit report, the worse their credit score. Although a recent Biden ruling would prohibit medical debt from appearing on credit reports, the ruling is now being challenged in court.[4]

Medical debt is the most common collection type reported on consumer credit records, and consumers report being contacted by debt collectors about medical debt more than any other type of debt. When compared to a variety of other debt types like banking and financial, telecom, retail, other (including insurance, educational and automotive debt), medical debt has accounted for the majority of past-due accounts appearing on consumer credit reports for the past few decades.[5]

Consumers have faced increased financial hardship due to the rise and promotion of one particular form of medical debt: medical credit cards and loans. From 2018 to 2020, consumers used specialty medical credit cards or loans to pay for almost $23 billion in health care expenses.[6] With interest rates of medical credit cards and loans averaging at 27% (while those of general credit cards average 16%), consumers also paid $1 billion in deferred interest from 2018 to 2020.[7] Deferred interest allows the consumer a period of time without interest, however, if the consumer is unable to pay in full by that time, the consumer is responsible for all interest that would have accrued since their original purchase date.[8] According to the Consumer Financial Protection Bureau, financial institutions encourage providers to promote medical credit cards to patients with promises that providers will receive payments faster and more easily than they would from insurance, or even that they can get patients to agree to more costly medical care.[9] Once patients use a medical credit card, they lose the opportunity to negotiate a lower hospital bill or ask for a hospital payment plan.[10]

Demographics of those experiencing medical debt

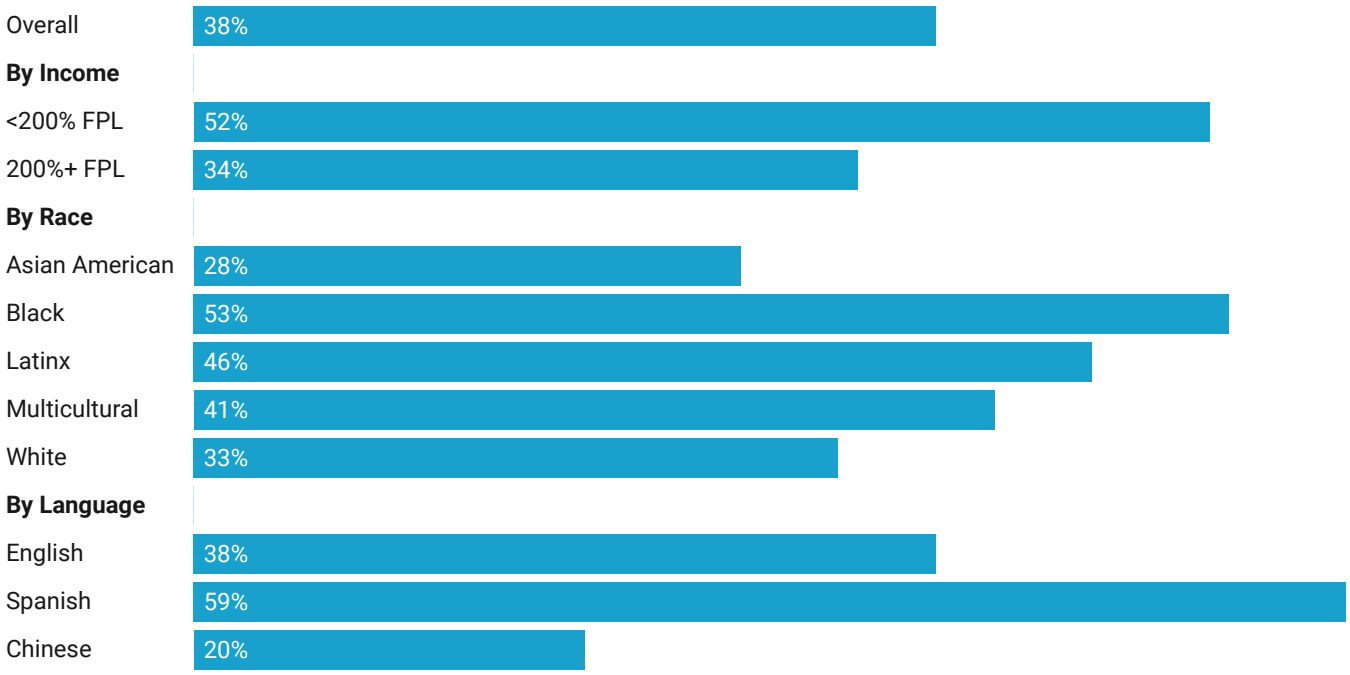
While medical debt affects a broad spectrum of Californians, those with low incomes and Black and Latinx consumers are the most commonly affected.

In 2023, 52% of low-income Californians reported medical debt, in comparison to 34% of those with higher incomes (above 200% of the Federal Poverty Level).[11] Among racial groups, the highest rates of medical debt were among Black (53%) and Latinx (46%) and multiracial (41%) populations, compared to white (33%), and Asian American (28%) populations. Additionally, 59% of Spanish speakers in California report they have medical debt, in comparison to English speakers (38%) and Chinese speakers (20%) (See Exhibit 1).[12]

In 2023, the median amount of medical debt in collections for Californians was $1,958 for white consumers with medical debt and $1,963 for communities of color.[13] While the amount of debt is relatively similar between groups, racial income and wealth gaps exacerbate the challenges for many individuals in communities of color in paying down debt. For example, in California, "for every $1 that white families earn, Asian American families earn $0.94, Black families earn $0.63, and Latinx families earn $0.52," according to an analysis by the Public Policy Institute of California.[14] In addition, as of 2021, the median wealth of U.S. white households was $205,400, while that of Black households was $27,100, and that of Latinx households was $48,700.[15]

Nearly half of women (48%) say they have debt due to medical or dental bills, compared to about a third of men (34%).[16] This disparity is undoubtedly due at least in part to the gender pay gap: in 2023, full-time, year-round working women earned 83% of what their male counterparts earned, according to a Census Bureau analysis.[17] Further, single women hold 32 cents of wealth for every dollar of wealth owned by a single man.[18] Women make up a disproportionate share of single parents[19] and therefore have greater responsibility for their children's medical expenses, and are more likely to bear the cost of childbirth, the most common reason for hospitalization in California.[20]

Exhibit 1. Percentage of Californians who say they have any type of medical debt, 2023



Note: FPL is federal poverty level.
Source: California Health Care Foundation/ NORC

Nationally, health care debt is most common among adults between ages 30 and 49, with 52% of this age group saying they have current health care debt. Many in this age group are likely to be parents, who are significantly more likely (58%) than non-parents (35%) to report having health care debt from their own or someone else's medical or dental bills. Additionally, of those ages 65 and over, 22% say they currently owe money due to medical or dental bills, illustrating the Medicare gaps that can leave seniors with substantial out-of-pocket costs.[21]

Medical debt is a problem for both those with and without insurance coverage. Many insured Americans are inadequately covered, defined as having out-of-pocket costs totaling 10% or more of their household income (or more than 5% for those under 200% FPL), or a deductible equivalent to 5% or more of household income. In a survey of working-age adults aged 19-64, those with inadequate health coverage exhibited the highest prevalence of medical and dental debt at 44%, followed by those uninsured at 35%. Among this age group, the prevalence of medical and dental debt was relatively similar between those with individual and marketplace coverage (32% had medical debt), employer insurance (29%), and Medicare (29%). Even 21% of those with Medicaid reported having medical and dental debt.[22] For some, the debt may have accrued prior to having Medicaid, but debt can be incurred while enrolled in Medicaid due to "noncovered services or private services that beneficiaries voluntarily agree to, clerical errors, fraud, or provider uncertainty about an individual's health insurance," according to a report by the Commonwealth Fund.[23]

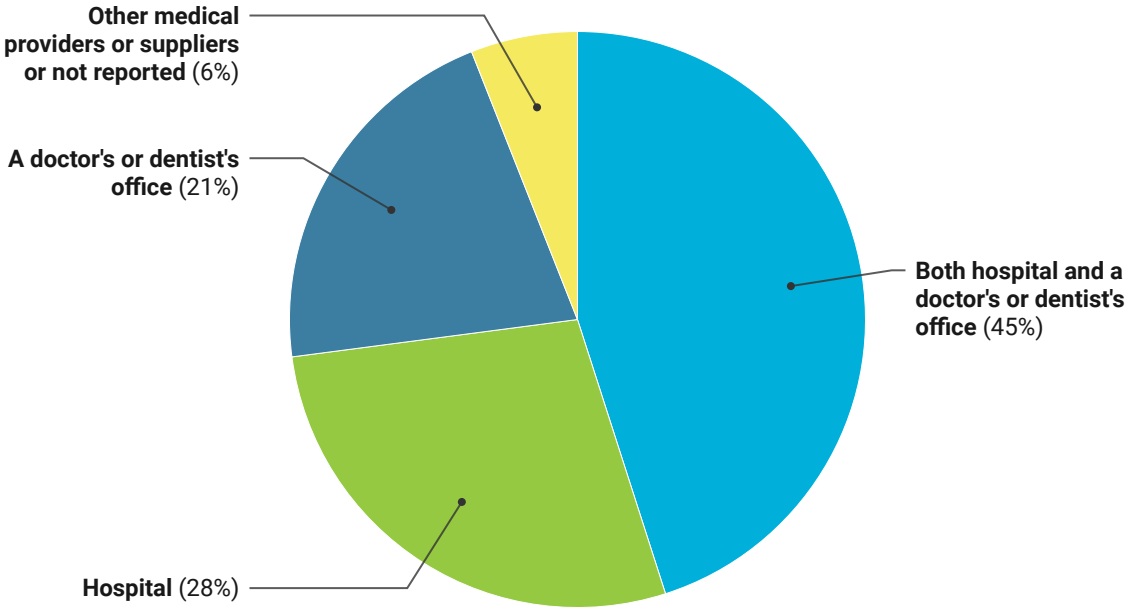
Causes of medical debt

The causes of medical debt can be divided into several categories, with many consumers experiencing multiple causes. Medical debt can accrue not only from an individual's own care, but also from the medical bills of family members: 12% of U.S. adults with medical debt reported that the debt was from someone else's care and another 34% reported that bills for both their own *and* someone else's care contribute to their debt.[24]

One-time events and hospital care

One-time, acute medical events, such as a single hospital visit or treatment for an accident, are the most common cause of medical debt. Nationally, 72% of adults with health care debt say bills from a one-time or short-term medical expense caused their debt.[25] A 2022 national survey indicates that, across all income groups, 73% of those with medical debt reported that the source of that debt was a hospital visit or both a hospital and doctor/dentist visit (see Exhibit 2). Those who had debt owed to a hospital were four times as likely to have debt of $5,000 or more (28%), compared to those with debt only from non-hospital providers (6%).[26]

Exhibit 2. Source of medical debt among U.S. adults ages 18 to 64, 2022



Source: Urban Institute

When such emergencies occur, many Americans do not have the savings to pay for them. According to a 2024 survey, 37% of Americans can't afford an unexpected expense over $400,[27] and 21% have no emergency savings at all. Having debt can exacerbate the problem of low savings. For 57% of those surveyed, paying down debt is a higher priority than saving for an emergency.[28]

High out-of-pocket costs with and without insurance

Research shows that medical debt is a problem for those with and without insurance coverage. In 2022, nationally, 64% of adults with medical debt incurred their debt during periods with insurance, while 21% incurred debt during periods without insurance. (The remainder accrued debt both when they had insurance and when they did not.)[29] Those with debt are more likely to have had high out-of-pocket expenses. A 2019 survey of adults showed that those with medical debt had an average of $1,593 in annual out-of-pocket medical spending, while those without medical debt had an average of $818. While uninsured survey respondents with medical debt had the highest median out-of-pocket spending amount in 2019 ($2,500), median spending for those with insurance was also high ($1,800 for privately insured and $2,000 for those with Medicare).[30]

Among the privately insured, cost sharing—including copayments, coinsurance, and deductibles—has been a more common reason for medical debt (18% of adults with medical debt) than services not being covered by the health plan (10%).[38]

Over recent decades, an increasing percentage of Californians with job-based coverage have had deductibles—in 2022, 77% of private-sector workers had deductibles compared to 33% in 2002—and the average size of those deductibles has grown rapidly.[39] The rise in deductibles and consumer out-of-pocket spending more broadly is largely due to employers shifting costs to employees in response to rapidly rising health care prices and employers' limited bargaining power with providers.[40]

High-deductible health plans (HDHPs) are also often cited as contributing factors to medical debt, particularly for individuals with lower or middle incomes. HDHPs typically feature lower

ACA Medicaid Expansion reduced medical debt and improved credit

Medicaid generally has little to no cost sharing, and can protect enrollees from the risk of medical debt. The implementation of the Affordable Care Act (ACA) in 2014 expanded eligibility for Medicaid and reduced the percentage of people with medical debt, along with the average size of medical debt.[31] In its first two years, the ACA Medicaid expansion reduced unpaid medical bills sent to collections by $900 per newly insured person, which translates to an overall reduction of $3.4 billion. The expansion reduced debt most for larger debt amounts.[32] Additionally, a 2017 study found that the ACA Medicaid expansion so improved households' financial health that there was an increase in available credit through improved terms valued at $520 million per year.[33] As mentioned, some Medicaid recipients with medical debt either accrued the debt prior to having Medicaid, or due to "noncovered services or private services, clerical errors, fraud, or provider uncertainty about an individual's health insurance."[34]

The ACA also provided subsidies to reduce premium and out-of-pocket spending for those with private insurance through Health Insurance Marketplaces like Covered California, and added new limits on out-of-pocket spending for individuals with employer-sponsored insurance. Despite these efforts, difficulty affording care due to out-of-pocket costs persisted for the privately insured.[35] In order to mitigate the effects of high out-of-pocket costs for Covered California enrollees, California implemented an enhanced cost-sharing reduction program in 2024. This program assists Covered California consumers by eliminating deductibles, as well as lowering copays, maximum out-of-pocket costs, and drug costs.[36] In its first year, the program reduced out-of-pocket costs for over 800,000 Covered California consumers.[37]

premiums and higher deductibles, which means patients pay a larger portion of their medical costs out-of-pocket before insurance begins covering costs.[41] According to a 2022 national study, 12% of adults with a high-deductible health plan have medical debt, while 9% of those with a non-high-deductible health plan have medical debt.[42] Individuals with medical debt and high deductibles also defer needed medical care at greater rates (by six times). This rate is highest for those with more treatable chronic diseases.[43]

Inadequate financial assistance assessments

Nearly half of non-profit hospitals report having outstanding payments owed by low-income patients who would have likely qualified for charity care under their financial assistance policies according to a 2019 Kaiser Health News (KHN) analysis. KHN estimated that non-profit hospitals had given up on collecting $2.7 billion in bills sent to patients who probably would have qualified for financial assistance under the hospitals' own policies if they had filled out the applications. In California, the amount of bad debt of patients eligible for charity care at non-profit hospitals totaled $136 million in 2019.[44] While some bad debt is written off by hospital systems, some is sold to debt collectors who pursue payment from patients.

Billing errors

Lastly, error-prone hospital billing systems often contribute to medical debt, as consumers have increasingly reported being billed for incorrect amounts or for debt they did not owe. From 2018 to 2021, consumer complaints about attempts to collect medical debt not owed increased by 31%. In these complaints, consumers reported that debt was incorrect because it had already been covered by themselves, health insurance, hospital financial assistance, or by workers compensation.[45] Similar to previous years, attempts to collect debt not owed made up over half of medical debt complaints the Consumer Financial Protection Bureau made to companies in 2023.[46]

Consequences of medical debt

Medical debt takes a toll on consumers' well-being by negatively impacting their mental and financial health, in addition to eroding their trust in the health care system and their motivation to pursue necessary medical care.

Mental toll

Being in debt has been shown to take a mental toll. In a survey of U.S. adults under age 65 with medical debt, 79% reported that their debt caused them or their family anxiety and worry.[47] A 2024 study by Undue Medical Debt indicated that people isolate themselves to try and cope with the distress that accompanies medical debt.[48]

The stress associated with high medical expenses and medical debt is not limited to those who are currently in debt. In 2023, 81% of Californians with incomes lower than 200% FPL reported being worried about being able to afford unexpected medical bills; 63% of Californians with incomes above 200% FPL shared the same worries.[49]

Financial health and ability to pay other bills

Medical debt can negatively impact Californians' ability to pay bills for other necessities, save for the future, and improve credit scores. According to a 2022 KFF survey, 63% of adults with medical debt said they or someone in their household cut back on spending on food, clothing, and basic household items to pay the debt. Additionally, 48% reported that they used all or most of their savings to pay the medical debt. Many also reported other serious actions like skipping payments on other bills, delaying college or buying a home, or taking on an extra job or working extra hours.[50]

Medical debt also has implications for housing security and stability, which is already a significant challenge for Californians. According to a Los Angeles County report, county residents with medical debt burden were "almost three and a half times more likely to be unstably housed than those not burdened, after accounting for gender, race/ ethnicity, age group, educational attainment, and household income."[51] Nationally, one in five U.S. adults with medical debt reported changing their housing situation as a result of their debt, with higher rates for Black (24%) and Hispanic (25%) populations, according to a KFF survey. Health care debt has had additional negative financial consequences for some, including lowering credit scores and contributing to bankruptcy, home foreclosures, or evictions.[52] In California, patients are protected from liens and foreclosures on property due to medical debt, but only if their income is below 400% of the federal poverty line (about $63,000 for a single person or $129,000 for a family of four in 2025[53]), and this policy has only been in place for primary residences since 2017[54] and for all real property since 2025.[55]

Access and motivation to pursue care

Having medical debt can inhibit access to needed health care. Californians with medical debt skip care due to cost at a higher rate (78%) than those with no medical debt (38%).[56] Adults with medical debt are also more likely to rely on home remedies or over-the-counter drugs (62%), and skip medications or tests recommended by a doctor (51%).[57]

Moreover, one in seven adults with medical debt say they have been denied care by a provider due to unpaid bills. Those with lower incomes and people of color (particularly Black adults) are more likely to report being denied subsequent care after incurring medical debt.[58]

Medical debt has caused many consumers to lose trust in medical providers and feel victimized by the health care system: a KFF/KHN poll showed that, of those with medical debt, only 15% said they have a lot of trust that providers have patients' best interests in mind.[59]

Existing federal and state policies to protect consumers from medical debt

Recent state and federal policies involving medical debt have provided some relief to consumers by improving transparency of hospital policies and access to financial assistance, and by mitigating the consequences of medical debt through policies like prohibiting its inclusion in credit reports.

Preventing or reducing debt

Limiting unexpected out-of-network billing

One common reason for new medical debt has been "surprise medical bills," resulting from consumers unwittingly receiving care from—and being charged for—out-of-network providers even when they accessed care at in-network facilities. These medical bills often include not only out-of-network deductibles and other cost sharing, but also the difference between the amount billed by the provider and the amount paid by the insurer, known as "balance billing."

State law partially addressed this problem with AB 72, which took effect in 2017.[60] This law protects certain consumers[61] who receive non-emergency services at in-network facilities by requiring that they pay no more than in-network cost sharing (such as copayments and deductibles) when billed by an out-of-network doctor.[62] If they follow their health insurance requirements, they are also protected from having their credit harmed, wages garnished, or liens placed on their primary residence.[63]

Congruently, the federal No Surprises Act, which took effect in January 2022, also protects patients with private insurance who inadvertently receive out-of-network care at in-network facilities. This law limits out-of-network cost sharing and prohibits balance billing for both emergency and non-emergency services.[64] The No Surprises Act added further protections for certain California consumers who were exempt from AB 72, including those enrolled in self-insured plans and those receiving emergency services.[65]

While AB 72 and the No Surprises Act protected consumers from many surprise medical bills, consumers remained unprotected from ground ambulance bills. To remedy this gap, California passed AB 716, which took effect in January 2024, and prevents patients in state-regulated (i.e., non-self-insured) private health plans from being charged surprise bills (more than their in-network cost-sharing amount) for ground ambulance rides.[66]

Increasing eligibility for financial assistance

Federal financial assistance for patients is available through all non-profit hospitals. Hospitals are required to create and publicize policies on: eligibility criteria for free and/or discounted care; basis for amounts charged to patients; the process for applying for financial assistance; and potential consequences of nonpayment. Federal policy does not, however, establish

minimum requirements for eligibility, or include requirements for a uniform financial assistance form or for an appeals process for patients disputing hospitals' financial assistance decisions.[67]

In addition to federal requirements for non-profit hospitals, California's Hospital Fair Billing Program requires all hospitals (except state-run facilities) to provide financial assistance applications to patients who are uninsured, as well as to those with high medical costs combined with incomes at or below 400% FPL.[68] Under this policy, California also requires hospitals to offer extended payment plans and written policies defining standards of debt collection.[69] Hospitals are required to comply with state financial assistance standards as a condition of licensure.[70] Finally, the Hospital Fair Billing Program caps discounted payments for financially qualified patients to the highest of various government payment rates (such as those for Medicare or Medi-Cal) for comparable health services.[71]

First implemented in 2007, the Hospital Fair Billing Program has been amended several times. Under AB 1020, which was implemented in January 2022, the patient eligibility level for financial assistance was increased from 350% FPL to 400% FPL, and hospitals became mandated to provide an application for charity care and financial assistance to patients before assigning a bill to collections or a third-party debt buyer.[72] AB 1020 also established an appeals and complaints process for patients who were denied financial assistance.[73] AB 2297, passed in 2024, added additional patient protections such as prohibiting liens on patient property to collect unpaid bills, prohibiting time limits on patients applying for assistance, and requiring hospitals to use patients' pay stubs and income tax returns (rather than monetary assets like personal savings accounts) to determine eligibility for charity care, discounted payments, or the amount of medical debt owed.[74]

In 2023, the County of Los Angeles undertook a significant project to explore the scale, impact and solutions to the medical debt problem in the county. In 2024, based on local data analysis and stakeholder discussions as part of the project, the county established the Financial Assistance Best Practices Committee, who were mandated to develop a toolkit to improve the financial assistance system for both patients and health care providers. One of the committee's first projects was to develop a standardized financial assistance application and policy, a web-based financial assistance portal, and promote presumptive eligibility software to local hospitals.[75]

Improving hospital transparency on prices, financial assistance, collections, and medical debt policies

The report produced by Los Angeles County as a result of this project found that medical debt could be reduced if medical facilities improved price and financial assistance policy transparency prior to care.[76] Subsequently, in 2024, the Los Angeles County Board of Supervisors issued an ordinance requiring acute care hospitals to report data on their debt collection and financial assistance operations; this would be used to inform financial assistance policy improvements and identify missed opportunities, such as patients who are eligible for financial assistance but are nonetheless sent to collections.[77] The ordinance also requires information like hospital reporting instructions and aggregate debt data be posted publicly and updated regularly on an online dashboard on a Department of Public Health website.[78]

Statewide, hospitals are required to report bad debt and charity care dollars as part of annual financial reporting to the California Department of Health Care Access and Information (HCAI).[79] Non-profit hospitals are also required to submit community benefit reports,[80] which include community benefit spending attributable to charity care.[81]

Using third-party debt buyers

While many third-party debt buyers purchase patient debts from hospitals at a discount and use aggressive tactics to attempt to collect the full amount from debtors, other third-party debt buyers like non-profit organization Undue Medical Debt benefit consumers. Undue Medical Debt purchases old, unpaid medical debt from providers and debt collectors for pennies on the dollar in order to erase the debt so that affected consumers no longer owe any payments.[82] According to federal law, hospitals cannot sell patient debt to a debt buyer unless the patient is ineligible for financial assistance, or the patient has not responded to a hospital's attempt to offer assistance for 180 days.[83] Notably, as part of AB 1020, California law prohibits debt buyers from charging interest or fees to patients.[84]

Los Angeles County is using the third-party debt buyer approach to eliminate many consumers' medical debt. The county reported that, despite the growth in coverage through Covered California and Medi-Cal expansions, medical debt remained relatively unchanged between 2017 and 2021; it labeled medical debt a public health issue on par with diabetes and asthma.[85] As of 2023, one in nine adults, or around 882,000 residents, in Los Angeles County were impacted by over $2.9 billion in outstanding medical debt.[86] The county initiated a pilot program, in partnership with Undue Medical Debt, that allocated $5 million to help 150,000 residents eliminate $500 million in debt. In addition to this debt purchase measure, the county is developing plans to boost hospital financial assistance programs and further track hospital debt collection practices.[87]

Mitigating consequences of debt

Eliminating some medical debt from credit reports

In April 2023, the three largest U.S. national credit agencies (Equifax, Experian, and TransUnion) agreed to stop listing some medical debt, including paid-off debts and those less than $500, on consumer credit reports.[88] While a majority of medical bill items were removed as a result, the Consumer Financial Protection Bureau reported in April 2024 that 15 million Americans still had medical bills on their credit reports.[89]

In January 2025, the Biden administration finalized a ruling proposed by the Consumer Financial Protection Bureau in 2024 to ban all medical debt (regardless of debt amount) from credit reports.[90] However, the fate of this ruling is uncertain and implementation has been stalled, as CFPB leadership has shifted under the new Trump administration and the rule is being challenged in court by credit reporting and credit union industries.[91] If successfully implemented, the Biden ruling would disallow creditors from using medical information related to medical debt when making credit eligibility determinations. The ruling would also prohibit all consumer reporting agencies (beyond the three largest) from including all medical debt in credit reports and ban the repossession of medical devices such as prosthetics as collateral.[92]

State policymakers have continued to seek ways to reduce the remaining burden of medical debt on credit scores. SB 1061, which went into effect in January 2025 in California,[93] blocks health care providers, as well as any contracted collection agencies, from sharing a patient's medical debt with credit reporting agencies.[94] If the debt is shared with a credit reporting agency, the medical debt will become void and unenforceable. This measure helps ensure medical debt does not inhibit consumers from securing a job, housing, loans, and more. This law does not, however, cover patients who pay hospital bills using medical credit cards or medical specialty loans.[95]

Improving property and wage protections

Some other states have limited how aggressively creditors may seek repayment for medical debt. New York and Maryland fully prohibit both liens and foreclosures due to medical debt, while California only prohibits liens and foreclosures for certain low-income populations. New York. Pennsylvania, North Carolina and Texas prohibit wage garnishment due to medical debt, yet California only extends this protection for certain low-income populations and in surprise billing situations. In New Hampshire, wage garnishment is not prohibited but creditors are required to return to court every pay period, which significantly limits creditors' ability to successfully garnish wages.[96]

Policy approaches to prevent and reduce medical debt and mitigate the consequences

Preventing or reducing debt

Making systemic changes to ensure health coverage and address high prices

A range of broader health policy options that aim to ensure more universal health coverage and address underlying health care affordability issues would also help to prevent or reduce medical debt. The most comprehensive solution for preventing or reducing medical debt in California could involve the implementation of a state single payer system. This solution would require a significant overhaul of our current fragmented health coverage system and would centralize the funding of health care and provide for all Californians receiving the same benefits. Most single payer proposals would require no patient cost sharing, or only limited cost sharing, at the point of care. A single payer system would guarantee universal access to high-quality health care for all Californians, thus ensuring that no one is left uninsured or underinsured.

California's current efforts to prevent cuts to federal funding for Medi-Cal and Covered California are important to ensure that the medical debt problems in this state do not get

worse. Almost 15 million Californians are enrolled in Medi-Cal, while another 1.6 million receive premium subsidies through Covered California; together this represents more than 40% of the population of the state.[97] With nearly two-thirds of Medi-Cal funding coming from the federal government,[98] and nearly 90% of Covered California recipients relying on federal financial assistance,[99] potential federal budget cuts to these programs would have a significant impact on health coverage for many Californians—which in turn could result in a dramatic increase in medical debt.

Addressing the underlying monumental problem of high health care prices in our system is another important approach to help prevent or reduce medical debt. For example, holding hospitals accountable for high health care prices and cost growth will be crucial given that nearly 73% of Americans with past-due medical debt report owing at least some of that debt to hospitals.[100] Current work at the California Office of Health Care Affordability aims to slow the growth in health care spending by setting enforceable spending targets that apply to California hospitals, medical groups, health plans, and other health care entities, including setting more ambitious targets for certain high-cost hospitals.[101] Further, California could require further scrutiny of mergers, which have proven to drive health care prices and insurance premiums up.[102] By tackling the underlying drivers of high health care spending, including prices and consolidation, California can help prevent patients from facing insurmountable bills that they are unable to pay.

Improving access to financial assistance

As detailed above, under state law hospitals in California are required to provide financial assistance; fashioning and implementing policies to improve access to this assistance could help prevent and reduce medical debt.

California could require hospitals to pre-screen more vulnerable patients for financial assistance eligibility before being discharged. Current state law requires hospitals to screen patients for financial assistance before being sent to collections, leaving patients unaware of their eligibility for an extended period of time. State policymakers could consider legislation like AB 1312, which would require hospitals to pre-screen those patients who are uninsured, enrolled in Medi-Cal or other means-tested programs, experiencing homelessness, or who owe more than $500 to a hospital.[103] Oregon,[104] Illinois,[105] and Maryland[106] have already implemented similar legislation to connect patients to assistance more rapidly. In Oregon, for example, a presumptive eligibility law implemented in 2024 upholds similar eligibility thresholds: patients who are uninsured, enrolled in state medical assistance programs, or owe a hospital more than $500.[107] A dollar threshold in this range addresses the fact that many households do not have the financial ability to cover a bill of this size; as mentioned above, 37% of all U.S. adults would not be able to cover an unexpected expense of $400 or would need to put it on a credit card, take a loan from a bank or a friend, or sell something, according to the Federal Reserve.[108] California's proposed pre-screening legislation would ease the burden on consumers and navigators by eliminating for many patients the need to find the policy and complete an application.

California could also create a uniform and simplified application form as well as a web portal to facilitate applying for financial assistance. Five other states have developed a standardized financial assistance application form.[109] Additionally, as part of efforts in Los Angeles County, a Financial Assistance Best Practices Committee is creating a standardized application, as well as a web-based portal, to increase access to the financial assistance process.[110] Dollar For, a national non-profit organization, has created a standardized financial assistance application process and helps patients by identifying eligibility and submitting applications to hospitals on their behalf.[111]

To monitor the impacts financial assistance programs are having and identify any remaining gaps over time, California could require hospitals to produce more detailed annual reports on financial assistance program use. For example, 11 other states including Nevada, Oregon, and Washington require hospitals to report on the numbers of financial assistance applications received, approved, denied, and appealed. Another five states including Maryland, Colorado, and Illinois also require hospitals to break down financial assistance and/or bad debt data by demographics of race, ethnicity, gender, and language.[112]

Mitigating consequences of debt

As summarized, medical debt leads to a range of mental and financial consequences. California can take action to reduce the burden of these hardships through a variety of policy changes to limit aggressive billing and collections practices.

While third-party debt collectors cannot collect interest on outstanding medical bills, and hospital extended payment plans must be interest fee,[113] California hospitals can still charge interest on debt not paid through a payment plan. California can expand its policy to limit or prohibit hospitals from charging interest on all medical debt, as eight other states have done.[114]

Next, in California current protections against liens and foreclosures on property due to medical debt apply only to patients with incomes at or below 400% FPL, or in surprise billing situations. State policy could enhance these protections to cover all consumers with medical debt. California could also follow seven other states by expanding homestead exemptions from limited to unlimited, allowing debtors to fully protect their primary homes from creditors during bankruptcy.[115]

Lastly, California can work to improve consumer education on medical credit cards and the realities of deferred interest from medical credit cards and loans. The legislature can also prohibit credit reporting of those who pay hospital bills using medical credit cards, which was not addressed in the new law on medical debt in credit reporting (SB 1061).

Conclusion

Medical debt affects four in ten Californians, among all income levels and including many with health insurance coverage. This widespread problem negatively impacts affected consumers' financial and emotional health, as well as their trust in the health care system and motivation to pursue care.

In addition to previous legislation intended to prevent or reduce medical debt or mitigate its consequences, California could look to policies in other states for reforms that improve access to hospital financial assistance and curb aggressive billing and collections practices. However, eradicating medical debt will most likely require a comprehensive shift toward universal coverage so that all consumers are insured equitably, and out-of-pocket costs are eliminated.

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University of California, Berkeley
2521 Channing Way
Berkeley, CA 94720-5555
(510) 642-0323
laborcenter.berkeley.edu

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About the author

Alexis Manzanilla is a policy researcher in the Health Care Program at the UC Berkeley Labor Center.

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