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Federalism, Private Law, and Medical Debt

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14.1 INTRODUCTION

Medical debt is the largest form of consumer debt in collections, with US$88 billion recorded on credit reports, affecting roughly one in five US households.[1] Medical debt pushes millions into financial distress and is exacerbated by harsh collection practices to garnish wages, seize assets, place liens on homes, and reduce creditworthiness. Concerned federal and state policymakers have pursued policies to protect consumers from medical debt.

Medical debt is a creature of private law, resulting from the contractual obligation by patients to pay for items and services provided by health care providers that are not covered by the patient's health insurance plan.[2] According to one account, public law is best suited to addressing diffuse problems where the costs are borne by a broad and undifferentiated public, while private law is better used to regulate concentrated costs borne by specific identifiable persons.[3] Public law's response is to tax, fine, and penalize conduct, whereas private law assigns liability for wrongful injuries to affected individuals.[4] Private law remedies can be the product of common law (torts, contracts, property) or legislation (statutory standards and remedies for private individuals).[5]

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[1] CFPB Estimates $88 Billion in Medical Bills on Credit Report, Consumer Fin. Prot. Bureau (Mar. 1, 2022), https://www.consumerfinance.gov/about-us/newsroom/cfpb-estimates-88-billion-in-medical-bills-on-credit-reports/.

[2] Wendy Netter Epstein, Price Transparency and Incomplete Contracts in Health Care, 67 Emory L. J. 1, 35 (2017).

[3] Aditi Bagchi, Other People's Contracts, 32 Yale J. on Regul. 211, 231 (2015).

[4] Id. at 236.

[5] Hanoch Dagan & Avihay Dorfman, Postscript to Just Relationships: Reply to Gardner, West, and Zipursky, 117 Colum. L. Rev. Online 261, 267 (2017) (describing fields such as employment

Consumer protection law writ large is best conceived of as a mixture of public and private laws. Most federal medical debt policies are forms of public law – namely administrative requirements imposed by government on health care and consumer finance entities. Nevertheless, significant gaps in the federal public law of medical debt persist, leaving an important role for states, particularly in the creation of private enforcement actions for violations of state consumer protections against medical debt. States have created both public law and private law protections that alter the patient's contractual obligation to pay medical debts, including prescribing standards for financial assistance, limiting the amounts providers may charge patients, barring certain collection actions, and empowering individuals to seek private remedies for violations.

The problem of medical debt is best addressed through combining federal and state, as well as public and private law approaches. Stronger national, public law standards to guard against medical debt are critical, but federal policy should retain a vital role for what states do well – policy innovation and filling the gaps in federal underenforcement through private remedies. Preserving a meaningful role for states and private law in consumer protection policy enhances separation of powers and serves as a check against federal regulatory failure.

14.2 THE PROBLEM OF MEDICAL DEBT AND ITS RACIAL INEQUITIES

The US burden of medical debt is extensive. Approximately 41 percent of adults, about 100 million individuals, currently carry medical debt totaling an estimated US$195 billion.[6] Medical debt has driven millions of people into financial distress through drained households' savings, garnished wages or liens on homes, damaged creditworthiness, delayed college or homebuying, or bankruptcy. Medical debt also worsens health as debtors forego essential health care and necessities, ration medications, or are denied care due to unpaid bills, ultimately leading to worse health outcomes.

The medical debt problem in the United States stems from two issues: unaffordable health care prices and aggressive debt collection practices. Uninsured patients are often charged prices that are significantly higher than the rates charged to government and commercial payers. Even individuals with health coverage are

law, consumer protection, and landlord-tenant law as private law despite that their doctrines are the product of statute and not common law).

[6] Lunna Lopes et al., Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills, Kaiser Fam. Found. (June 16, 2022), https://www.kff.org/health-costs/report/kff-health-care-debt-survey/; Noam Levey, 100 Million People in America Are Saddled with Health Care Debt, Kaiser Fam. Found. Health News (June 16, 2022), https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.

not protected, as many are "underinsured" and unable to pay for their growing share of their health care costs through cost-sharing and deductibles.[7]

Harsh debt collection practices further exacerbate the problem of unmanageable medical bills. These practices include selling debts to collection agencies, suing patients, seeking foreclosure or liens on patients' homes, garnishing wages, seizing bank accounts and property, charging high interest rates, requiring up-front payment before providing additional care, and even seeking arrest for failing to appear in court for a debt collection hearing. Medical debt collection imposes significant financial, emotional, and health-related hardship for patients.

Unmanageable medical debt is associated with higher levels of stress, anxiety, and poorer health – often called the "financial toxicity" of unaffordable health care.[8]

Consumers who lack legal representation may find themselves ill-equipped to fight debt collection actions, which fill the dockets of state civil courts. According to one report, more than 70 percent of debt collection cases end in default judgment against the debtor, usually because the debtor did not respond to the action or show up in court.[9] Once a judgment is entered, the debt balloons from added court fees and accrued interest.

Medical debt disproportionately affects Black and Hispanic families, who historically have lower levels of wealth and health insurance coverage.[10] Medical debt is also more prevalent in Southern states that did not expand Medicaid, where nearly 60 percent of those who fall into the coverage gap are people of color.[11] Kaiser Family Foundation reports that 56 percent of Black adults and 50 percent of Hispanic adults have medical debt, compared with 37 percent of White adults.[12] One study found that Black adults were 2.6 times more likely to carry medical debt than their White counterparts, where differential incomes and insurance status

[7] Sara R. Collins et al., State of U.S. Health Insurance in 2022, Commonwealth Fund (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey; Christopher T. Robertson, Exposed: Why Our Health Insurance Is Incomplete and What Can Be Done about It (2019).

[8] Peter A. Ubel et al., Full Disclosure – Out-of-Pocket Costs as Side Effects, 369 New Engl. J. Med. 1484 (2014).

[9] Pew Charitable Trs., How Debt Collectors Are Transforming the Business of State Courts (May 6, 2020), https://www.pewtrusts.org/en/research-and-analysis/reports/2020/05/how-debt-collectors-are-transforming-the-business-of-state-courts.

[10] Berneta L. Haynes, The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families, Nat'l Consumer L. Ctr. (Mar. 2022), https://www.nclc.org/images/pdf/medical-debt/RacialHealth-Rpt-2022.pdf.

[11] Raymond Kluender et al., Medical Debt in the U.S., 2009–2020, 326 JAMA 250 (2021); Robin Rudowitz et al., How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?, Kaiser Fam. Found. (Mar. 31, 2023), https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[12] Lopes et al., supra note 6.

explained nearly one-fifth of the gap.[13] Blacks were more likely than Whites to be contacted by a collection agency or borrow money to pay off medical debt.[14] Debt collection suits are more prevalent in Black communities, with 40 percent more judgments than in mostly White neighborhoods.[15] The racial inequities in medical debt create a vicious cycle: Historically marginalized communities carry more debt, avoid care, skip medications, and become sicker as their chronic conditions are poorly managed, which results in higher costs, more debt, and worse health outcomes.[16]

The United States is experiencing a growing medical debt crisis. As a result, many Americans have come to fear medical bills more than the illness itself.[17] Federal and state policymakers' efforts to create consumer financial protections against medical debt have been unable to stem the problem.

14.3 FEDERAL AND STATE PROTECTIONS AGAINST MEDICAL DEBT

14.3.1 *Federal Law and Policy Protecting Consumers from Medical Debt*

In 2010, the Dodd-Frank Act (Dodd-Frank) and the Affordable Care Act (ACA) marked a historic inflection point in federal policies to address the problem of medical debt in the United States, through the creation of the Consumer Financial Protection Bureau (CFPB) and new Internal Revenue Service (IRS) requirements for tax-exempt hospitals' billing and collections policies.[18] Federal medical debt policies largely take the form of public law. The CFPB can impose administrative requirements on credit reporters and debt collectors to ameliorate the negative impacts of medical debt on US consumers, and the IRS regulates the financial assistance and collection policies of tax-exempt hospitals. Yet the federal public law of medical debt is inadequate in scope and enforcement, leaving consumers without remedies when faced with medical debt or collection actions that violate federal standards.

[13] Jacqueline C. Wiltshire et al., Medical Debt and Related Financial Consequences among Older African American and White Adults, 106(6) Am. J. Pub. Health 1086, 1086–91 (2016).

[14] Id.

[15] Jessica LaVoice & Domokos F. Varmossy, Racial Disparities in Debt Collection, SSRN (Oct. 2019), https://ssrn.com/abstract=3465203.

[16] Lopes et al., supra note 6; Haynes, supra note 10, at 5–7 (describing medical debt as a consequence and driver of the racial health gap).

[17] NORC at the University of Chicago, Issue Brief: Americans' Views of Healthcare Costs, Coverage, and Policy (Mar. 26, 2018), https://www.norc.org/Research/Projects/Pages/americans-views-of-healthcare-costs-coverage-and-policy.aspx.

[18] Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376 (2010); Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010, as amended by Health Care Education and Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010)).

14.3.1.1 Consumer Financial Protection Bureau Action on Medical Debt

The CFPB oversees consumer financial products and services, including debt collection and credit reporting. Dodd-Frank authorized the CFPB to regulate credit reporting and collection of medical debts under the Fair Debt Collection Practices Act (FDCPA) and Fair Credit Reporting Act (FCRA), but the CFPB lacks authority under the FDCPA to regulate collection activities by health care providers themselves, only those by third-party collection agents.[19]

To date, CFPB's actions have largely taken the form of studies, reports, and nonbinding guidance to credit reporting agencies on the treatment of medical debt under its FCRA authority.[20] Driven by these reports and public pressure, credit reporting agencies and industry actors have voluntarily adopted changes to the treatment of medical debt on credit reports. First, the three major credit reporting agencies agreed to remove paid medical debts and those under US$500 from credit reports and to delay reporting of medical debts for one year.[21] Second, credit-scoring organizations agreed to reduce the weight assigned to medical debts compared to nonmedical debts when calculating credit scores (in the case of Fair Isaac Corporation [FICO]) or exclude medical debts from credit scores altogether (in the case of VantageScore).[22] Nevertheless, larger and older unpaid medical debts still remain on credit reports, which could be used by employers, mortgage lenders, or landlords to discriminate against consumers with high health costs from chronic conditions or a disability. Moreover, the industry's voluntary measures are nonbinding, reversible, and virtually unenforceable. Despite CFPB's regulatory authority, its policy actions on medical debt can hardly be characterized as "law."

[19] Medical Debt Burden in the United States, Consumer Fin. Prot. Bureau 42–43 (Mar. 1, 2022), https://www.consumerfinance.gov/data-research/research-reports/medical-debt-burden-in-the-united-states/.

[20] See, for example, CFPB Data Point: Medical Debt and Credit Scores, Consumer Fin. Prot. Bureau (2014), https://www.consumerfinance.gov/data-research/research-reports/medical-debt-and-credit-scores/; Data Point: Recent Changes in Medical Collections on Consumer Credit Records, Consumer Fin. Prot. Bureau (Apr. 29, 2024), https://www.consumerfinance.gov/data-research/research-reports/recent-changes-in-medical-collections-on-consumer-credit-records/; Medical Debt Burden in the U.S., Consumer Fin. Prot. Bureau (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022–03.pdf; Compliance Bulletin and Policy Guidance, Medical Debt Collection and Consumer Reporting Requirements in Connection with the No Surprises Act, Consumer Fin. Prot. Bureau (Jan. 13, 2022), https://www.consumerfinance.gov/compliance/supervisory-guidance/cfpb-bulletin-2022-01-medical-debt-collection-consumer-reporting-requirements-in-connection-with-no-surprises-act/.

[21] National Credit Bureaus Support Consumers with Changes to Medical Debt Collection Debt Reporting, Consumer Data Indus. Ass'n (Mar. 18, 2022), https://www.cdiaonline.org/news/2022/03/18/equifax-experian-and-transunion-support-u-s-consumers-with-changes-to-medical-collection-debt-reporting/.

[22] Fair Isaac Corp., FICO Score 9 (July 13, 2015), https://www.fico.com/blogs/impact-medical-debt-collections-ficor-scores; Medical Debt and the Changes to VantageScore, VantageScore (Aug. 10, 2022), https://vantagescore.com/medical-debt-and-the-changes-to-vantagescore/.

Consumer advocacy organizations have urged the CFPB to pass rules to codify and expand protections by eliminating medical debts from credit reports and to increase enforcement against medical debt collectors who use unfair practices, such as failing to ensure patients are screened for financial assistance eligibility before pursuing collection.[23] It would take an act of Congress to expand the scope of the FDCPA to include "first-party" collection actions by health care providers, which means these collectors are not barred from using unfair, abusive, or deceptive collection practices.[24]

14.3.1.2 IRS Rules for Tax-Exempt Hospitals under the Affordable Care Act

The ACA created requirements, implemented by the IRS, restricting the billing and collection practices for tax-exempt hospitals.[25] One provision mandates hospitals to maintain and publicize their financial assistance policies, including the criteria for free or discounted care.

Nevertheless, the IRS rules do not prescribe the method that hospitals must use to establish eligibility for financial assistance, leaving it up to their discretion. Another requirement is that hospitals must limit charges for eligible patients to the "amounts generally billed" to insured patients for emergency or medically necessary care, and they cannot charge gross charges, which are the hospital's full, undiscounted rates. Lastly, the IRS rules restrict nonprofit hospitals from engaging in "extraordinary collection actions" unless they have attempted to determine if the patient is eligible for financial assistance.

There are several gaps in IRS rules' protections against medical debt. First, the rules are underinclusive – they do not apply to the 42 percent of hospitals that are for-profit or government-run or to physician practices.[26] Second, hospitals have complete discretion in determining eligibility for financial assistance, which can be manipulated using restrictive income or asset requirements or difficult application processes. Third, the IRS rules are under-enforced, with no reported sanctions despite the widespread use of extraordinary collection actions and publicized

[23] Letter from 91 Organizations to Rohit Chopra, Dir. of the Consumer Fin. Prot. Bureau (Sept. 26, 2022), https://www.nclc.org/resources/letter-asking-for-rulemaking-to-ban-medical-debt-from-credit-reports/; Letter to Rohit Chopra, Dir. of the Consumer Fin. Prot. Bureau (Mar. 6, 2023), https://communitycatalyst.org/medical-debt-sign-on-letter-to-cfpb-march-6/.

[24] Blake N. Shultz et al., Hospital Debt Collection Practices Require Urgent Reform, Health Affs. Forefront (May 2, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220429.408324/.

[25] 26 U.S.C. § 501(r). Additional Requirements for Charitable Hospitals, Final Rule, 79 Fed. Reg. 78954 (Dec. 31, 2014), codified at 26 C.F.R. § 1.501(r)-1–1.501(r)-7.

[26] Hospitals by Ownership Type, Kaiser Fam. Found. (2022), https://www.kff.org/other/state-indicator/hospitals-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; This Memphis Hospital System Flouts IRS Rules by Not Publicly Posting Financial Assistance Policies, ProPublica (May 21, 2021), https://www.propublica.org/article/this-memphis-hospital-system-flouts-irs-rules-by-not-publicly-posting-financial-assistance-policies.

violations.[27] These gaps leave patients with medical debt with inadequate protections and no recourse even if hospitals violate federal tax rules in their pursuit of payment. There is no private cause of action for violations of federal tax rules, even when the patient loses their home, life savings, or creditworthiness.

14.3.1.3 Other Federal Actions That Prevent Creation of Medical Debt

More effective than laws targeting the collection and reporting of medical debts are federal efforts that stop the debts from being created in the first place. The most important of these was the ACA's expansion of Medicaid to nearly all low-income adults earning less than 138 percent of the federal poverty limit (FPL), which has significantly reduced medical debt and racial health coverage disparities.[28] Yet, following the 2012 Supreme Court ruling decoupling a state's decision to expand Medicaid from the state's existing Medicaid funding, many Republican-led states have chosen not to expand Medicaid, leaving about two million low-income and mostly non-White adults uninsured and exposed to medical debt.[29]

Federal public law on medical debt has several key shortcomings: (1) The CFPB's actions to date are nonbinding nudges that rely on voluntary industry practice; (2) the ACA's rules for tax-exempt hospitals are underinclusive, underpowered, and under-enforced; (3) the Supreme Court made Medicaid expansion optional for states, leaving millions uncovered;[30] and (4) none of these federal laws provide consumers with individual remedies in the event their lives are wrongly upended by medical debt.

14.3.2 *State Laws*

Even with federal action on medical debts, states have not abandoned their traditional roles as consumer protectors and policy generators. States have passed laws expanding upon federal protections, filling gaps, and innovating new approaches to the medical debt problem. States have created both public law and private law protections, creating standards for financial assistance policies, applying them to a

[27] Noam Levey, Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?, Kaiser Fam. Found. Health News (Dec. 21, 2022), https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/; Jordan Rau, Patients Eligible for Charity Care Instead Get Big Bills, Kaiser Fam. Found. Health News (Oct. 14, 2018), https://kffhealthnews.org/news/patients-eligible-for-charity-care-instead-get-big-bills/.

[28] Kluender et al., supra note 11; Haynes, supra note 10.

[29] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); Robin Rudowitz et al., supra note 11.

[30] Status of State Medicaid Expansion Decisions: Interactive Map, Kaiser Fam. Found. (Mar. 27, 2023), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

broader range of health care providers, barring certain collection actions, and, in some instances, empowering private individuals to sue to remedy violations.

Several states have implemented laws aimed at ensuring fair medical billing and collection across all hospitals, regardless of their tax status or ownership. For instance, states have limited the amount that hospitals can charge patients who fall below specified income levels.[31] One example is the Hospital Fair Pricing Act in California, which restricts the amount that California hospitals and emergency physicians can charge uninsured patients who earn less than 400 percent of the FPL or insured patients whose medical bills exceed 10 percent of household income.[32] By defining these income and affordability thresholds, states limit hospitals' discretion in determining eligibility for financial assistance and standardize these limits across all hospitals. Most state laws do not extend these financial assistance requirements to nonhospital providers, such as physician groups.

Furthermore, many states have put limits on the medical debt collection practices of health care providers and their debt collectors. At least twenty-one states have laws that restrict providers' medical debt collection practices, including limitations on interest rates, foreclosing or placing a lien on a patient's home or property, wage garnishment, seeking debtors' arrest, credit reporting, or assigning the debt to a collection agency.[33] The scope of these limits varies, with some states applying them broadly to all patients, and others limiting the protections by the patient's income, uninsured status, or eligibility for financial assistance. For example, New Mexico bars any collection actions against patients earning less than 200 percent of the FPL.[34] Maryland requires hospitals to refund patients for amounts wrongly sought in collections from patients eligible for free care.[35] Finally, states can engage in policy innovation, such as Colorado's law prohibiting hospitals from seeking collection of medical debts if they are not in compliance with federal price transparency rules,[36] or Maryland's requirement for hospitals to report on their financial assistance, collection actions by race, ethnicity, and other demographic characteristics.[37]

[31] Andrea Bopp Stark & Jennifer Bosco, An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States, Nat'l Consumer L. Ctr. (Nov. 2021), https://www.nclc.org/resources/report-an-ounce-of-prevention/.

[32] Cal. Health & Safety Code §§ 127400–127446 (hospitals), 127450–127462 (emergency physicians).

[33] Christopher T. Robertson et al., New State Consumer Protections against Medical Debt, 327 JAMA 121 (2022); Hospital Community Benefit Program: Community Benefit State Law Profiles Comparison, Hilltop Inst., http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last accessed Sept. 2024); Medical Debt Burden in the United States, supra note 19, at 42–43.

[34] Patients' Debt Collection Protection Act, N.M. Stat. §§ 57-32-1–57-32-10.

[35] Medical Debt Protection Act, Md. Code, Health-Gen. § 19-214.2.

[36] H.B.22-1285, 74th Gen. Assemb., First Reg. Sess. (Co. 2022), codified at Colo. Rev. Stat. §§ 25-3-801–25-3-803.

[37] Medical Debt Protection Act, supra note 35.

To be sure, there can be unintended consequences from overly broad free-care requirements for providers, such as exacerbating financial precarity of less profitable hospitals or service lines.[38] Despite these concerns, states' fair pricing and collection laws have not caused widespread financial strain on hospitals.[39] States have gone farther than federal laws to create standards to protect patients from medical debts.

State law requirements for hospital financial assistance and medical debt collection are forms of public law, enforced administratively by the health department or state attorney general. However, states can provide additional enforcement through a private right of action for individuals aggrieved by unlawful medical billing or collection practices and by strengthening patients' legal defenses in collection actions against them.[40]

Colorado and Connecticut present models for private enforcement of hospital medical debt collection laws. Colorado creates a private right of action for aggrieved patients to sue health care providers that violate the billing and collection requirements individually or via class action for actual damages, statutory damages, and attorneys' fees.[41] Connecticut makes it an unfair trade practice for any provider to demand payment from patients or report debts to credit reporting agencies for prohibited medical bills.[42] Although few patients have prevailed under these laws, in one case, the Connecticut Supreme Court found that a physician's unlawful billing and collection practices violated state unfair trade practice laws, awarding the patient actual and punitive damages and attorney's fees.[43]

The designation of medical billing practices as an unfair trade practice is advantageous in two ways: (1) It provides a private remedy to individuals harmed by unlawful medical billing and collection practices, and (2) attorneys' fees and punitive damages incentivize attorneys to take such cases on behalf of consumers. Nearly all states have an Unfair and Deceptive Acts or Practices (UDAP) law, and state legislatures can reduce legal burdens on patients by classifying medical debt billing and collection practices as unfair trade practices *per se* under their state UDAP statutes.

[38] Jill Horwitz & David M. Cutler, The ACA's Hospital Tax-Exemption Rules and the Practice of Medicine, Health Affs. Forefront (Mar. 3, 2015), https://www.healthaffairs.org/content/forefront/aca-s-hospital-tax-exemption-rules-and-practice-medicine.

[39] Glenn Melnick & Katya Fonkych, Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges, 32(6) Health Affs. 1101, 1101–08 (2013).

[40] Gianetti v. Siglinger, 279 Conn. 130, 136–37 (2006) (finding in favor of patient in defense against surgeon's billing and collection action that provider's balance-bills violated state unfair medical billing and collection practices and unfair trade practices laws).

[41] Colo. Rev. Stat. § 25.5-3-506.

[42] Conn. Gen. Stat. §§ 20-7f(b)–(c), 38a-193(c).

[43] Gianetti, supra note 40, at 138–39.

14.4 FEDERALISM, PRIVATE LAW, AND MEDICAL DEBT

The pervasive problem of medical debt poses a question of regulatory design – whether consumer protections are best instituted at the federal or state level, using the tools of public law or private law. The policy shortcomings cataloged here demonstrate that the problem requires the combined and concerted action of national and state governments, where states can fill gaps and innovate new policies to build on a federal floor and provide private remedies to supplement inadequate administrative enforcement.

14.4.1 *The Role of Private Law and Private Remedies in Consumer Protection*

The problem of medical debt is a consumer protection problem with both the diffuse harm of unaffordable health care costs borne by the public, employers, and businesses, as well as concentrated harms of medical debts and collection actions borne by individuals and households specifically. Thus, legal solutions for the medical debt problem should combine public and private laws. Nevertheless, extant consumer protections from medical debt tend to focus on public law solutions and neglect private law remedies for individuals. Most of the legal and policy solutions described above focus on regulating conduct of the health care providers, collection agents, and credit reporting bureaus in the creation, collection, and management of medical debt.

Violations of the federal public law on medical debt are enforced, if at all, through administrative penalties, loss of tax-exempt status, or public sanction on the entities, not liability to the affected individuals. In practice, this means that a low-income patient who wrongfully loses their home, is unable to buy food or pay rent, or is unable to fill a necessary prescription due to medical debt has no recourse against the hospital that failed to apply its financial assistance policy or pursued extraordinary collection actions in violation of federal laws. The hospital might lose its tax-exempt status if the IRS were to seek enforcement of the violation, but there is no remedy for the harms suffered by the patient. The combination of inadequate administrative enforcement with the severity of harms inflicted on individual debtors is a prototypical situation for public laws to be supplemented with private enforcement.[44]

Clear and protective standards for consumers could, theoretically, protect the public from unaffordable medical debt if they deterred abusive conduct by creators and collectors of medical debt.[45] Consumer advocacy organizations have called for stronger public law standards: The IRS could specify clearer eligibility standards and blanket prohibitions on harsh collection actions, and CFPB could issue rules

[44] Bagchi, supra note 3, at 240.
[45] Danielle D'Onfro, Error-Resilient Consumer Contracts, 71 Duke L.J. 541, 575 (2021).

eliminating medical debts from credit reports.[46] In June 2024, CFPB issued a proposed rule that would, if finalized, remove all medical debts from credit reports and prohibit creditors from considering medical debts in credit eligibility determinations.[47] Even with stronger rules, the extent of consumer protection depends critically on enforcement, and public enforcement of consumer protection laws against medical debt has been abysmal.[48]

The classic vehicle of consumer protection is the UDAP law, which has been adopted by all fifty states to extend the consumer protections of the Federal Trade Commission through a combination of enforcement by state attorneys general and private parties.[49] Private enforcement of state UDAP laws plays a critical role in supplementing public enforcement, serving a public benefit of deterrence, and expanding states' limited resources. Private enforcement of UDAP laws also creates private benefit by creating legal recourse for affected individuals through reduced burdens of proof, minimum damage recoveries, attorneys' fees, and court costs, which compensate the individual for the harms suffered and enable them to secure legal representation.[50] Consumers struggle to secure legal representation to defend their individual contract disputes with providers over medical bills because these are typically too small in dollar amount for lawyers to take the case and courts are unwilling to aggregate these cases in class action.[51] UDAP remedies thus provide both a private cause of action and increased access to justice by incentivizing attorneys to take these cases.[52]

14.4.2 *Federalism and Private Law Checks against Regulatory Failure*

The biggest challenge for the medical debt policy is not codifying new consumer protections but lack of enforcement. Compared with the federal government, states possess a historic advantage in the creation and enforcement of rights, obligations,

[46] Noam Levey, Medical Debt Affects Millions, and Advocates Push IRS, Consumer Agency for Relief, NPR (Mar. 7, 2023), https://www.npr.org/sections/health-shots/2023/03/07/1161473744/medical-debt-affects-millions-and-advocates-push-irs-consumer-agency-for-relief (describing letters by advocacy organizations to CFPB and IRS on Mar. 6, 2023).

[47] Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information, Consumer Fin. Prot. Bureau (June 18, 2024), 89 Fed. Reg. 51682.

[48] D'Onfro, supra note 45, at 576 ("[C]onsumer protection depends on enforcement . . . Public enforcement's track record is abysmal").

[49] Dee Pridgen, The Dynamic Duo of Consumer Protection: State and Private Enforcement of Unfair and Deceptive Trade Practices Laws, 81 Antitrust L.J. 911, 911 (2017).

[50] Id. at 937.

[51] Christopher T. Robertson, Medical Bills Are Open-Price Contracts: A Victory for the Little Guy, Harvard L. Petrie-Flom Ctr. Bill of Health Blog (Oct. 3, 2017), https://blog.petrieflom.law.harvard.edu/2017/10/03/medical-bills-are-open-price-contracts-a-victory-for-the-little-guy/.

[52] Ulbrich v. Groth, 310 Conn. 375, 411, 78 A.3d 76, 101 (2013) (noting that Connecticut's Unfair Trade Practice Act "was intended to provide a remedy that is separate and distinct from the remedies provided by contract law when the defendant's contractual breach was accompanied by aggravating circumstances").

and liabilities among private parties, particularly in the areas of health and safety regulation and consumer protection.[53] Private enforcement can fill gaps and supplement public enforcement of consumer protection laws, as illustrated by state UDAP laws.[54] State consumer protection laws enhance consumers' legal protections against medical debt both by supplementing public law with private law remedies and by making the protections more resilient to erosion from federal regulatory failures.

Federal regulatory failure is a growing problem, driven by capture,[55] abdication by presidential administrations,[56] budgetary cuts from Congress,[57] and curtailment of agency authority by the Supreme Court.[58] The primary regulatory agencies in charge of consumer protections against medical debt – the CFPB and IRS – have been prominent targets of the varied forms of administrative evisceration from all three branches of government.[59] Given that federal agency decisions not to enforce are generally unreviewable by courts, states can make up for and check federal regulatory inaction.[60] Concurrent state consumer protection laws with both private and administrative enforcement promote the goals of federalism: policy innovation, diversification of remedies, increased accountability for industry actors and government regulators, responsiveness and superior information of local market conditions and practices, and dynamic regulation.[61]

The recipe for better consumer protections against medical debt combines (1) stronger federal public law standards that operate as a floor for more protective state

[53] Amy Widman, Advancing Federalism Concerns in Administrative Law through a Revitalization of State Enforcement Powers: A Case Study of the Consumer Product Safety and Improvement Act of 2008, 29 Yale L. & Pol'y Rev. 165, 166 (2010).

[54] Pridgen, supra note 49, at 932–33.

[55] Id. at 926 ("[S]tate UDAP enforcement can serve as a check on federal agencies that may be "captured" by their regulatory 'clients'").

[56] Amy Widman, Protecting Consumer Protection: Filling the Federal Enforcement Gap, 69 Buff. L. Rev. 1157 (2021) (describing the abandonment of federal consumer protection enforcement by the CFPB and FTC under the Trump administration).

[57] Emily Cochrane & Alan Rappeport, House Republicans Vote to Rescind I.R.S. Funding, N.Y. Times (Jan. 9, 2023), nytimes.com/2023/01/09/us/politics/house-republicans-irs-funding.html.

[58] Lisa Heinzerling, The Supreme Court Is Making America Ungovernable, The Atlantic (July 26, 2022), https://www.theatlantic.com/ideas/archive/2022/07/supreme-court-major-questions-doctrine-congress/670618/; Lisa Heinzerling, How Government Ends, Boston Rev. (Sept. 28, 2022), https://www.bostonreview.net/articles/how-government-ends/ (describing how the Supreme Court is systematically eroding administrative agencies' authority to govern, exemplified in West Virginia v. EPA).

[59] See Widman, supra note 56, at 1161–6257; Seila Law v. CFPB, 591 US _, 140 S. Ct. 2183 (2020) (holding the for-cause removal protections for the Director of the CFPB unconstitutional, allowing the President to remove the Director at will); Vanessa Williamson, Cutting IRS Funding Is a Gift to America's Wealthiest Tax Evaders, Brookings (Jan. 26, 2023), https://www.brookings.edu/blog/fixgov/2023/01/26/cutting-irs-funding-is-a-gift-to-americas-wealthiest-tax-evaders/ (describing persistent underfunding of the IRS).

[60] Widman, supra note 53, at 167.

[61] Pridgen, supra note 49, at 932–33; Widman, supra note 53, at 167–68.

regulation, and (2) concurrent state consumer protections enforceable by the state attorney general and a private right of action with minimum statutory damages, attorneys' fees, and costs. This recipe reaps the benefits of federalism, public law standards, and private law remedies to provide a fuller set of tools to protect individuals from medical debt. Importantly, these protections would be further enhanced by efforts to provide better health coverage to more people, particularly Medicaid expansion in all states.

Medical debt policy should preserve a meaningful role for states and private law to check against regulatory failure by federal public law solutions. Federalism's separation of powers stems not only from the division of authority between the federal government and the states but also between the levers of public law and private law. An overlapping and mutually reinforcing interplay between federal and state as well as public and private law fosters stronger protections against medical debt for individuals and households.