PATIENTS RISING

A PATIENTS' RIGHT TO KNOW REPORT · JULY 2026

Medical Bankruptcy in America

340B hospitals as creditors in consumer bankruptcy — a six-state review of 903 filings.

903	6	45%	$6.62M
BANKRUPTCY FILINGS REVIEWED	STATES, COAST TO COAST	LISTED VERIFIED 340B HOSPITAL DEBT	VERIFIED 340B DEBT, LINE BY LINE

Executive summary

Over the past year, Patients Rising reviewed roughly 900 consumer bankruptcy filings across six states — Virginia, Wisconsin, Washington, Colorado, Louisiana, and Maine — and tallied every medical creditor listed on every schedule. The filings are public records. We have used no names.

We set out to answer one narrow, empirical question: when Americans are pushed into bankruptcy carrying hospital debt, which hospitals appear as creditors, and how often? The answer is consistent across very different states. The hospital systems that recur most often are large nonprofit systems that participate in the federal 340B Drug Pricing Program — the program that lets "safety-net" hospitals buy outpatient drugs at deep federal discounts on the premise that the savings will serve low-income patients.

Of the 903 filings reviewed, **406 (45 percent) listed a debt to a hospital we could verify as a 340B participant, totaling $6,622,650**. These are not projections or estimates. They are line items, entered under penalty of perjury, by households listing everything they owed. Four findings stand out:

1. **The pattern is a pattern, not an anecdote.** In every state, a small number of dominant nonprofit 340B systems account for most of the verified debt. In Wisconsin, one system (Aurora) appears in nearly a third of all filings reviewed. In Washington, the Providence family of hospitals accounts for the plurality of verified creditor lines. In Maine, a single system (Northern Light) carries roughly 63 percent of the state's verified 340B debt.

2. **The largest balances fall on the lowest-income households.** The single largest verified hospital balance in the series — $386,758, owed to CHRISTUS Highland Medical Center in Louisiana — sits on the schedule of a rural household whose entire monthly income was $1,800 and for whom medical debt was 98 percent of everything they owed.

3. **The record itself documents the transparency gap.** In Colorado, 40 filings name only a parent corporation, not the hospital that treated the patient — roughly $348,000 in likely-340B debt that cannot be tied to a specific covered entity. If a patient cannot identify the hospital that billed them, they cannot find that hospital's charity-care policy, let alone apply for it.

4. **This is specific to nonprofit 340B systems.** The analysis deliberately distinguished 340B participants from for-profit hospitals; for-profit facilities were tagged and excluded from the verified totals in dozens of filings. The recurring creditors are the tax-exempt, discount-receiving systems.

OUR ASK: DISCLOSURE, NOT DEMOLITION

We do not claim that 340B participation causes any individual bankruptcy, and this paper is explicit about what the data can and cannot show. Our ask is correspondingly narrow: define "340B patient" in federal law; require standardized, audited public reporting that separates charity care actually delivered from bad-debt write-offs claimed as community benefit; and require point-of-care disclosure so patients know when they are being treated at a 340B participant and how to apply for assistance. The Tax-Exempt Hospital Transparency Act (H.R. 9504), advanced by the House Ways and Means Committee this month, is a meaningful first step toward the first two.

Introduction: the question, and why bankruptcy records answer it

American health policy has argued for two decades about how often medical bills cause bankruptcy. That argument has largely been fought with surveys, and surveys can be contested. This project asks a different, more answerable question, and answers it from primary documents.

When a household files for consumer bankruptcy, it must list — under penalty of perjury — every creditor and the amount owed. Those schedules are public. They are one of the very few places where the relationship between a specific hospital and a specific low-income patient becomes visible to anyone outside the hospital's billing office. They do not capture every patient or every dollar; most people with medical debt never file for bankruptcy. But for the households who do reach that point, the schedules show exactly which institutions were owed money at the moment of financial collapse.

We used that window to test a specific claim at the center of the 340B debate. The 340B program exists on the premise that participating hospitals use their drug discounts to serve low-income and uninsured patients. If that premise holds, one would not expect the same nonprofit 340B systems to appear, over and over, as creditors in the bankruptcies of low-income patients in their own communities. Yet that is what the

filings show. The purpose of this paper is to document that pattern rigorously, to state plainly what it does and does not prove, and to draw the narrow policy conclusions the evidence supports.

Background: the 340B program and the transparency gap

The 340B Drug Pricing Program, created in 1992, requires drug manufacturers to sell outpatient drugs to eligible "covered entities" — including disproportionate-share hospitals, critical-access hospitals, and certain clinics — at steep discounts. The discounts are substantial, and the program is now enormous. In 2024, 340B discounted purchases reached a record $81.4 billion, up 23 percent in a single year, with hospital-type covered entities accounting for roughly 87 percent of the total.[1] The program is now larger than many of the public programs it was meant to supplement.

The rationale is that the savings — the spread between the discounted purchase price and what the hospital is reimbursed — will underwrite care for vulnerable patients. But three features of the program make it nearly impossible to confirm that this happens:

The key terms are undefined in law. "340B patient," "charity care," and "community benefit" are the three concepts that determine whom the program is supposed to serve and how — and none has an enforceable federal definition. When HRSA attempted to enforce a narrow definition of "340B patient," a federal court struck it down. In *Genesis Healthcare, Inc. v. Becerra* (2023), the U.S. District Court for the District of South Carolina held that HRSA's interpretation exceeded the statute, leaving the agency without a workable definition of the very population the program exists to serve.[2]

There is no pass-through requirement. Nothing in federal law requires a 340B hospital to share its discount with the patient at the point of care. When the Government Accountability Office examined the issue, it found that at contract pharmacies, only 30 of the 55 covered entities it reviewed offered discounts on 340B drugs to low-income, uninsured patients; the rest charged full price.[3] The discount is guaranteed to the hospital; the benefit to the patient is not.

Community benefit is self-reported and porous. Nonprofit hospitals report "community benefit" on IRS Form 990, Schedule H, largely without independent audit. Analysis by the Lown Institute found that 80 percent of nonprofit hospitals spent less on charity care and community investment than the estimated value of their tax exemption — a combined "fair share deficit" of $25.7 billion in a single year.[4] And under hospital accounting conventions, a bad-debt write-off — including the discharge of a patient's balance at the end of a bankruptcy — can end up counted toward the very community-benefit figures the hospital reports. In other words, the same write-offs these bankruptcy filings document may be reported back to the public as evidence of the hospital's generosity.

This is the gap the Patients' Right to Know Campaign exists to surface. The bankruptcy filings are not the whole story of 340B; they are the part of the story that is verifiable in public records.

Methodology

Sample. We reviewed federal consumer bankruptcy filings (primarily Chapter 7 and Chapter 13) in six states: Virginia, Wisconsin, Washington, Colorado, Louisiana, and Maine. In total, 903 filings were reviewed and coded. This is a convenience sample of filings, not a random sample of all bankruptcies or all patients, and the findings should be read accordingly (see Limitations).

Creditor coding. For each filing, we recorded every medical creditor listed on the debtor's schedules and the amount owed. Each hospital creditor was then classified against the federal 340B registry:

VERIFIED 340B	LIKELY 340B	NOT 340B
Confirmed as a registered 340B covered entity. Only these balances count toward the "verified 340B debt" totals in this paper.	Very probably a participant (e.g., a parent corporation) but not tied to a specific registered facility. Tracked separately; excluded from headline totals.	For-profit or otherwise non-participating facilities, explicitly tagged and excluded — dozens of filings across the six states.

Household coding. For each filing we also coded the household's monthly income and expenses (and therefore monthly margin), total liabilities, and — critically — the medical share of the household's unsecured debt. This last measure was designed to test a specific objection: that a "medical bankruptcy" might really be a filing dominated by student loans or credit-card debt with only a small medical bill attached. By computing medical debt as a percentage of unsecured debt for every filing, we can report honestly where medical debt dominates and where it does not.

Privacy. All personal identifiers — names, case numbers, employers, and precise geographic detail that could identify a filer — have been removed. Illustrative cases in this paper are described only in general, non-identifying terms. The filings are public, but the campaign's position is that these families have been through enough.

A note on conservatism. The verified-vs-likely distinction is deliberately conservative: where a named entity could not be confirmed against the 340B registry with confidence, its balance was classified "likely" and excluded from the verified totals reported here. Because those excluded "likely" balances (see Colorado, below) are real hospital debts that simply could not be pinned to a registered facility, **the verified totals in this paper understate rather than overstate the program's true footprint in these filings.**

Findings

1. The headline pattern

Across the six states, 406 of 903 filings — 45 percent — listed a verified debt to a 340B-participating hospital, totaling $6,622,650.

STATE	FILINGS REVIEWED	WITH VERIFIED 340B DEBT	VERIFIED 340B DEBT
Virginia	275	146 (53%)	$2,154,860
Wisconsin	104	67 (65%)	$1,160,048
Washington	146	47 (32%)	$1,044,903
Colorado	187	70 (37%)	$982,747
Louisiana	130	44 (34%)	$953,851
Maine	61	32 (52%)	$326,241
Six-state total	**903**	**406 (45%)**	**$6,622,650**

Table 1 · Verified 340B hospital debt by state, 903 consumer bankruptcy filings, 2025–2026.

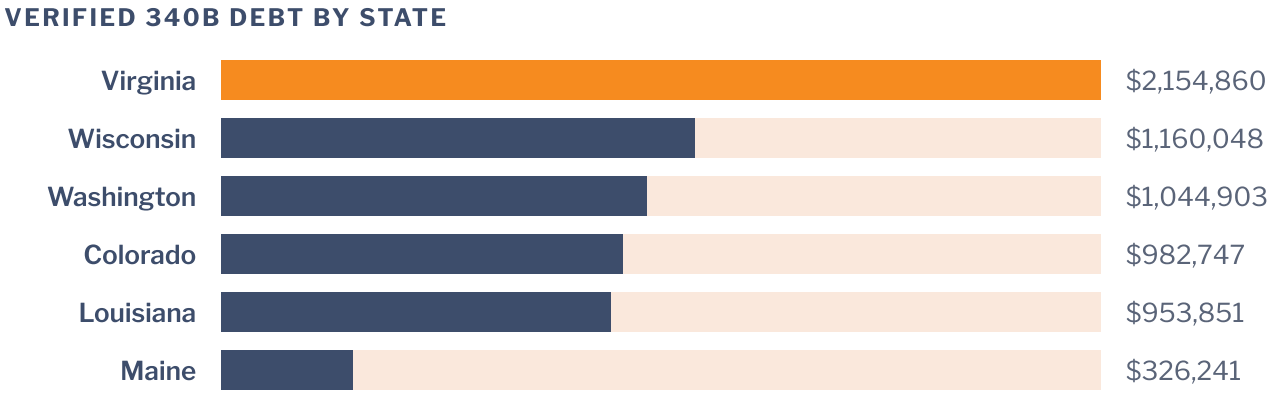

Figure 1 · Verified totals understate the true footprint: “likely 340B” balances (e.g., ~$348,000 in Colorado parent-only filings) are excluded.

2. Concentration in a few dominant systems

In each state, the verified debt is not spread evenly across hospitals — it clusters in a handful of dominant nonprofit systems.

- **Virginia:** Bon Secours Mercy Health appears in 46 verified filings, followed by Centra Health (23), Sentara Healthcare (20), and Carilion Clinic (12). Four systems carry the majority of the state's verified debt.
- **Wisconsin:** Aurora Health Care is the single most frequent creditor in the entire series, appearing in roughly 32 of 104 filings reviewed — nearly one in three — followed by Ascension Wisconsin (17).
- **Washington:** The Providence family of hospitals (including Swedish and Kadlec affiliates) is the most common 340B creditor, appearing in 17 of 44 verified filings and on the plurality of verified creditor lines; MultiCare and Confluence Health follow.
- **Colorado:** UCHealth appears in 27 verified filings and Children's Hospital Colorado in 15.
- **Louisiana:** Two systems — CHRISTUS and Ochsner — account for roughly 84 percent of the state's verified 340B debt, and CHRISTUS carries the single largest hospital balance in the entire series.
- **Maine:** Northern Light Health carries about 63 percent of the state's verified 340B dollars (roughly $206,000 across 16 filings) in a market effectively shared by two systems.

> *When a single system's billing and charity-care practices touch this large a share of a state's most financially distressed patients, the absence of public reporting on how that system uses its 340B savings is not an abstraction. It is a live accountability gap.*

3. Who these households are

The filings with verified 340B debt are, overwhelmingly, low- and moderate-income households in genuine financial distress. Among verified-340B filings, median monthly income ranged from roughly $3,100 to $4,200 across the six states — on the order of $37,000 to $50,000 a year for households that frequently include dependents. Large shares were running negative monthly margins (more expenses than income) at the time of filing: 48 percent in Virginia and 44 percent in Colorado, for example.

Most of these filings are Chapter 7 (liquidation) rather than Chapter 13 (repayment) — 73 percent in Virginia, 81 percent in Washington, 85 percent in Colorado, 89 percent in Maine — indicating households with little or nothing left to reorganize. Louisiana is the notable exception, with a majority of filings under Chapter 13.

4. What the medical share does — and does not — show

We coded the medical share of unsecured debt for every filing precisely so that we would not overstate the case. The honest result is two-sided, and both sides matter.

Across all verified-340B filings, medical debt is typically a substantial minority of the household's unsecured debt — median medical share ranged from about 15 percent (Maine) to 33 percent (Washington). In other words, this is not a dataset cherry-picked for maximal medical debt. Because we counted every 340B creditor on every schedule, the data include many households whose bankruptcies were driven by a mix of causes, with hospital debt as one contributor among several. That the same nonprofit 340B systems recur as creditors even across this broad set is precisely the point: their presence in these filings is not an artifact of selecting only the most medical cases.

At the same time, in the most severe filings, medical debt clearly dominates. Between 13 and 41 percent of verified filings (highest in Washington) show medical debt at half or more of all unsecured debt, and the largest-balance cases are almost entirely medical. The Louisiana household owing $386,758 to CHRISTUS Highland carried medical debt equal to 98 percent of everything it owed. A Virginia household owed $82,206 to Sentara at 88 percent medical. A Wisconsin household owed $196,098 to Froedtert at 97 percent medical. These are not filings about student loans with a hospital bill attached. They are filings about a hospital bill.

THE DEFENSIBLE SYNTHESIS

We do not claim 340B participation causes bankruptcy. We claim, and the data show, that 340B hospitals recur as creditors in the bankruptcies of low-income patients — and that no public reporting lets anyone see whether those same patients ever received the charity care the 340B discount is supposed to fund.

5. The largest balances

A handful of individual balances illustrate how large a single hospital debt can loom in a low-income household's collapse. All are de-identified and described at the district level.

STATE	VERIFIED 340B BALANCE	HOSPITAL	MONTHLY INCOME	MEDICAL SHARE OF UNSECURED
Louisiana	$386,758	CHRISTUS Highland	$1,800	98%
Virginia	$228,699	Mary Washington	$5,160	81%
Colorado	$200,000	Parkview (Pueblo)	$3,043	63%
Wisconsin	$200,000	Aurora	$5,643	65%
Wisconsin	$196,098	Froedtert	$1,416	97%
Maine	$97,000	Northern Light	$2,708	83%

Table 2 · Largest verified 340B balances in the series, de-identified and described at the district level.

6. Transparency artifacts in the record itself

Two findings are not about dollars but about what the filings reveal regarding the system's opacity.

Parent-only naming (Colorado). In 40 Colorado filings, the patient could name only a parent corporation — Centura/CommonSpirit, Intermountain/SCL, Banner — because that is all their bill identified. Roughly $348,000 in likely-340B debt cannot be resolved to a specific covered entity. This is a transparency failure captured in real time: a patient who cannot identify the hospital that treated them has no realistic path to that hospital's financial-assistance policy.

Bad debt as community benefit. In case after case, a hospital carries a low-income patient's balance to the point of bankruptcy, then writes it off at discharge — a write-off that, under reporting conventions, can be counted toward community benefit. The collection process produces no recovery for the hospital while doing real harm to the patient, and the eventual write-off may then be reported as generosity. If the debt was always going to be written off, the question the data pose is why the household had to pass through federal bankruptcy court to get there.

Limitations

This paper is only as credible as its candor about what it cannot show. The principal limitations:

It is a convenience sample. These 903 filings were reviewed as they were obtained, not drawn as a random sample. The percentages here (for example, "45 percent of filings") describe the filings we reviewed; they cannot be projected onto all bankruptcies in a state without a defined sampling frame. We report counts and shares within the sample, not population estimates.

There is no denominator of patients. Bankruptcy filings capture households at the extreme end of financial distress. They say nothing about how many of a hospital's patients received charity care and never filed. The data can show that 340B hospitals recur as creditors; they cannot, by themselves, quantify how often 340B savings do reach patients.

Correlation is not causation. The presence of a 340B hospital on a bankruptcy schedule does not establish that the hospital, or the 340B program, caused the bankruptcy. We make no such claim.

Schedules are self-reported. Debtors list creditors as they understand them. Hospital names are often incomplete, inconsistent, or given only as a parent corporation (see Colorado). Some balances are listed without a dollar figure; where an amount could not be parsed, it is excluded, which means our verified totals understate rather than overstate the true 340B debt.

The verified/likely line is conservative and imperfect. Confirming that a named hospital is a registered 340B entity is a judgment against an imperfect public registry. When uncertain, we classified a balance "likely" and excluded it. This is why Colorado's parent-only balances sit outside the verified totals — and why the true 340B footprint is almost certainly larger than the numbers here.

None of these limitations undercuts the central, modest finding — that the same nonprofit 340B systems recur as creditors in these filings, and that the public cannot see whether those systems' discounts reach the patients who end up as their debtors. They do mean the finding should be stated as a documented pattern, not as a causal or population-level claim.

The findings in national context

This review lands in the middle of two well-documented national realities.

The first is the long-running debate over medical bankruptcy. The Consumer Bankruptcy Project's 2019 study found that about two-thirds of debtors cited a medical contributor to their bankruptcy, a share essentially unchanged by the Affordable Care Act.[5] Critics have argued that such studies conflate contribution with causation; a 2018 study using hospital-admission records put the causal share far lower.[6] Our data speak to neither extreme. By coding the medical share of every filing, we sidestep the causation debate entirely and report a narrower, verifiable fact: which hospitals are owed money, and how much.

The second reality is the sheer scale of medical debt and the widening gap between nonprofit hospitals' tax benefits and their charity care. Roughly 100 million Americans carry some form of health care debt;[7] an estimated $220 billion is owed, with about 3

million people owing more than $10,000 each.[8] Meanwhile, investigative reporting has documented that a large majority of hospitals — including major nonprofit systems — sue patients, report them to credit agencies, or deny non-emergency care over unpaid bills, often without first screening those patients for the charity care they qualify for.[9] Our findings are a state-level, document-based corroboration of that national picture, focused specifically on the 340B systems whose discounts were meant to prevent exactly this outcome.

100M

Americans carry some form of health care debt[7]

$220B

Estimated medical debt owed nationwide[8]

$25.7B

Nonprofit hospitals' combined "fair share deficit" in a single year[4]

Policy implications and recommendations

The evidence supports a narrow, transparency-focused agenda. We are not calling for the 340B program to be cut or dismantled. We are calling for the public to be able to see whether it works as intended. Three steps follow directly from the findings.

1 Define "340B patient" in federal law.

The term that determines whom the program is meant to serve has no enforceable meaning after *Genesis*. Congress should supply one. Without a definition, there is no standard against which to measure whether a hospital's 340B savings are reaching the intended patients — the patients who, this review shows, are turning up as debtors.

2 Require standardized, audited public reporting that separates charity care from bad-debt write-offs.

The single most important reform is to stop allowing bad debt — including balances discharged in bankruptcy — to be blended into community-benefit figures. Hospitals receiving 340B discounts should report, in an audited and standardized form, the charity care they actually delivered, separately from the debt they wrote off after pursuing patients. The Tax-Exempt Hospital Transparency Act (H.R. 9504), which the House Ways and Means Committee ordered reported this month, moves squarely in this direction: it would require large tax-exempt hospitals to file audited financials, report real charity-care data, and — for high-revenue 340B participants — disclose 340B patient counts and net 340B payments on a facility level.[10] Congress should pass it.

3 Require point-of-care disclosure.

No patient in this dataset was told, at the point of care, that they were being treated at a 340B participant, what charity-care policy applied, or how to apply for it. Patients receiving care at a 340B hospital should be informed of that fact and of their right to apply for financial assistance — before the bill, not after the discharge. The Colorado parent-only filings show why: patients cannot exercise rights they cannot identify.

A fourth principle follows from the first three: no hospital receiving 340B discounts should pursue collections, credit reporting, or litigation against a patient it has not first screened for financial assistance. The screening should precede the debt.

A NOTE ON THE PATH FORWARD

These recommendations do not require waiting for comprehensive reform. Patients Rising has developed companion proposals — appropriations report language for the FY 2027 Labor-HHS bill directing HRSA to build a public framework for reporting 340B savings and their allocation to direct patient benefit, and to pilot point-of-sale notification so patients know when 340B pricing has been applied; and authorizing language amending Section 340B(a)(5) of the Public Health Service Act to make patient-benefit reporting a condition of participation.

Both are deliberately modest: they define "direct patient benefit," ask hospitals to report what they already know, and change no one's eligibility. They are detailed in a separate companion document, available on request.

Where the research needs to go

This six-state review is a proof of concept for a method, not the last word. The natural next phases:

Expand the state footprint, with a defined sampling frame. The most valuable methodological upgrade is to move from a convenience sample to a defined one — for example, all Chapter 7 filings in a jurisdiction over a fixed period — so that within-sample shares can be defended as representative and compared across states. Additional states, chosen to vary hospital-market structure (single-dominant-system vs. competitive), would test whether concentration drives the pattern.

Build a denominator. Pairing bankruptcy data with hospital-level charity-care and patient-volume data would begin to answer the question the filings alone cannot: of the low-income patients a 340B hospital serves, how many receive charity care versus how many end up as creditors in bankruptcy?

Link filings to hospital financial disclosures. Matching the systems that recur here to their IRS Form 990 Schedule H filings — their reported community benefit, bad debt, and charity care — would let us test directly whether the write-offs documented in these

bankruptcies reappear in the hospitals' self-reported generosity.[11] This is the empirical heart of the "bad-debt-as-community-benefit" concern.

Analyze contract pharmacies and the point-of-sale gap. The GAO's finding that many covered entities do not extend discounts to low-income patients at contract pharmacies deserves a bankruptcy-linked follow-up: are the systems that recur as creditors also the ones with the largest contract-pharmacy operations?

Resolve the classification frontier. Investing in facility-level verification — closing the "likely" gap (for example, the parent-only corporate names in Colorado) — would tighten every number in this report and, in every case observed so far, would raise the verified totals rather than lower them.

Partner for peer review. Because the causation debate is contested and the stakes are high, the credibility of this work would be strengthened by collaboration with academic health-services researchers and by making the coding methodology available for external replication.

Pursued together, these steps would move the project from "here is a documented pattern in six states" to "here is a measured, replicable estimate of how often 340B hospitals appear in their own patients' financial collapse — and whether their reported community benefit reflects it." That is the evidentiary standard the policy debate deserves, and the one this review is built to reach.

Appendix A: State summaries

Virginia · 275 filings · 146 (53%) verified · $2,154,860

The largest verified total in the series. Dominant systems: Bon Secours, Sentara, Centra, Mary Washington/Carilion. Largest balance: $228,699 (Mary Washington).

Wisconsin · 104 filings · 67 (65%) verified · $1,160,048

Highest exposure rate in the series. Aurora Health Care appears in roughly a third of all filings reviewed. Largest balances: $200,000 (Aurora) and $196,098 (Froedtert, 97% medical).

Washington · 146 filings · 47 (32%) verified · $1,044,903

Heaviest single-ecosystem concentration: the Providence/Swedish/Kadlec family dominates verified creditor lines. Largest balance: a filing anchored by $146,168 to Kadlec.

Colorado · 187 filings · 70 (37%) verified · $982,747

Deepest billing opacity: 40 filings name only a parent corporation (~$348,000 unresolved). Dominant systems: UCHealth, Children's Colorado. Largest balance: $200,000 (Parkview, Pueblo).

Louisiana · 130 filings · 44 (34%) verified · $953,851

Carries the largest single balance in the series: $386,758 (CHRISTUS Highland), a household on $1,800/month with medical debt at 98% of everything it owed. Dominant systems: CHRISTUS, Ochsner, Our Lady/FMOL, North Oaks.

Maine · 61 filings · 32 (52%) verified · $326,241

Second-highest exposure rate, in a two-system market. Northern Light Health carries ~63% of verified dollars in a market shared by two dominant systems.

Appendix B: Glossary

340B Drug Pricing Program — Federal program (1992) requiring manufacturers to sell outpatient drugs to eligible "covered entities" at steep discounts, on the premise that savings support care for low-income patients.

Covered entity — A hospital or clinic registered to participate in 340B (e.g., disproportionate-share hospital, critical-access hospital, child site).

Community benefit — Activities a nonprofit hospital reports (largely on IRS Form 990, Schedule H) to justify its tax exemption, including charity care, Medicaid shortfalls, education, and research.

Charity care — Free or discounted care provided to patients who qualify under a hospital's financial-assistance policy.

Bad debt — Patient balances the hospital does not expect to collect and writes off. Distinct from charity care, though the two are frequently conflated in public discussion.

Verified 340B debt — In this study, a balance owed to a hospital confirmed as a registered 340B covered entity. The conservative basis for all headline totals.

Notes

1. Fein AJ. "The 340B Program Hit $81 Billion in 2024 (+23%)." *Drug Channels*, December 2025; HRSA, "2024 340B Covered Entity Purchases."
2. *Genesis Healthcare, Inc. v. Becerra*, U.S. District Court for the District of South Carolina, November 3, 2023.
3. U.S. Government Accountability Office. "Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement." GAO-18-480, June 2018.
4. Lown Institute. "Hospital Fair Share Spending, 2024" (analysis of 2021 IRS Form 990 data).
5. Himmelstein DU, Lawless RM, Thorne D, Foohey P, Woolhandler S. "Medical Bankruptcy: Still Common Despite the Affordable Care Act." *American Journal of Public Health* 109, no. 3 (March 2019): 431–433.
6. Dobkin C, Finkelstein A, Kluender R, Notowidigdo MJ. "Myth and Measurement — The Case of Medical Bankruptcy." *New England Journal of Medicine* 378 (2018): 1076–1078.
7. "100 Million People in America Are Saddled With Health Care Debt." KFF Health News, June 2022.
8. "The Burden of Medical Debt in the United States." KFF, February 2024.
9. "Hundreds of Hospitals Sue Patients or Threaten Their Credit." KFF Health News, December 2022.
10. Tax-Exempt Hospital Transparency Act, H.R. 9504, 119th Cong. (2026); ordered reported by the House Committee on Ways and Means, July 1, 2026.
11. Internal Revenue Service. "Instructions for Schedule H (Form 990)."