Hospital Medical Debt:
Aggressive Debt Collection Practices in 340B Hospitals Despite Higher Cancer Burdens

Hospital medical debt continues to pose significant challenges for patients across the US, particularly for those facing serious illnesses where medical care is unexpected, intensive, prolonged, and costly. Medical debt often arises from unplanned or unavoidable health needs, leading to substantial financial strain during an already challenging time.

Findings from a 2024 national survey by the National Consumers League (NCL) and Morning Consult show that nearly half of US adults have experienced medical debt, and among those with medical debt, 54% skipped needed follow-up care and 51% depleted most or all of their savings.[1] Research from the American Cancer Society Cancer Action Network similarly found that almost half of patients with cancer and cancer survivors incurred medical debt and that those with debt were three times more likely to fall behind on recommended screenings.[2]

The 340B Drug Pricing Program is a federal program that enables eligible hospitals and clinics serving a high percentage of low-income, uninsured, Medicare and Medicaid patients to purchase outpatient medications at reduced prices, with the expectation that the revenue from these drug sales will be used to improve and expand care for vulnerable populations. Oncology treatments account for a disproportionate share of drug utilization in the 340B Drug Pricing Program, with a Congressional Budget Office study finding that oncology therapies represent roughly 41% of all 340B purchases, nearly three times higher than any other therapeutic class.[3] In 2025, the Health Care Cost Institute published a report showing that close to one-third of infusions for Medicare-fee-for-service patients with blood cancer–related drug administrations between 2018 and 2022 occurred in 340B outpatient settings.[4]

Given the interdependent relationship between the 340B program and patients' access to cancer care, NCL has sought to better understand the extent to which 340B hospitals engage in medical debt practices affecting vulnerable patient populations and identify opportunities for improvement in debt collection processes.

This analysis examines if medical debt practices exist and intensify in hospitals with higher oncology volumes, the differences in debt practice behaviors between 340B and non-340B oncology care sites, and how debt practices may impact patients navigating both cancer treatment and financial hardship.

"Medical debt forced me to use work bonuses, start a GoFundMe, and withdraw from my 401k after cancer treatment. Bills went to collections, damaged my credit, and made it hard to get an apartment—despite care from a hospital meant to use 340B savings to help patients like me. No one should have to decide between choosing to fight for their life or worrying about the debt that comes with fighting for your life."

- Dr. Garrina Ross, Metastatic Breast Cancer Thriver and Tigerlily ANGEL Advocate

340B Hospitals Are More Likely to Adopt Medical Debt Collection Policies

Contrary to the presumption that 340B hospitals will utilize revenue from 340B-discounted drugs to improve the care and services provided to vulnerable populations, **findings from this analysis show that a higher proportion of 340B hospitals have medical debt collection policies compared with non-340B hospitals. These policies include legal actions,[5] such as lawsuits, liens, and wage garnishment, as well as credit reporting and care denial or deferral for unpaid bills.**

Across practices, 340B hospitals show a higher presence of medical debt policies, ranging from 36% to 75% compared with 23% to 62% in non-340B hospitals (**Figure 1a**).[6] This pattern is consistent when examining the types of legal actions that are allowed by hospitals (**Figure 1b**). Patients who rely on 340B hospitals tend to be medically and financially vulnerable, meaning that aggressive debt collection environments can heighten financial and emotional strain.

Figure 1a: Hospital Debt Practices for 340B vs Non-340B Hospitals

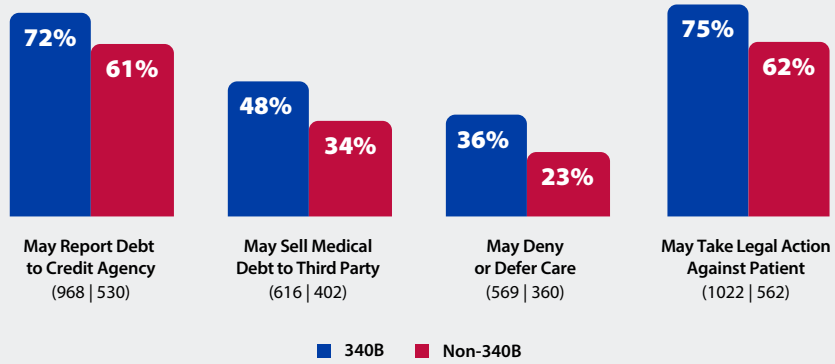
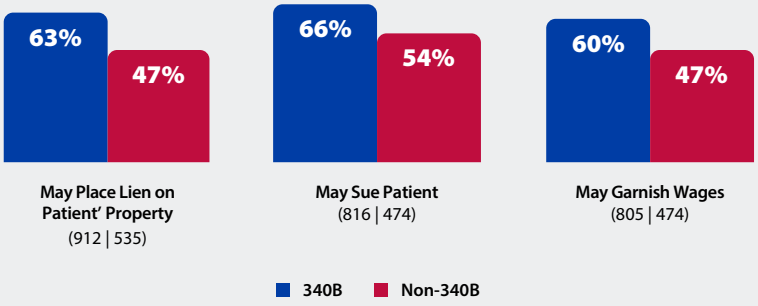


Figure 1b: Hospital Debt Practices for 340B vs Non-340B Hospitals, by Type of Legal Action



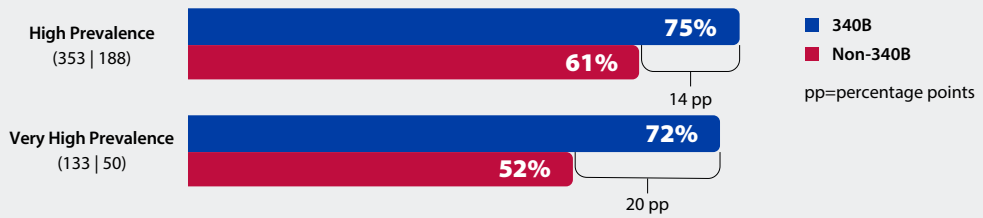
Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

Medical Debt Practices Persist in Hospitals With Higher Cancer Prevalence

Hospitals that treat larger cancer populations care for some of the most medically vulnerable individuals. Yet the analysis shows that medical debt practices do not abate in these settings. Instead, 340B hospitals with high cancer prevalence continue to exceed non-340B hospitals with similar cancer prevalence in the presence of debt collection policies.

Among hospitals with high cancer prevalence and very high cancer prevalence,[7] legal action policies remain notably more common in 340B hospitals. In high cancer prevalence hospitals, 75% of 340B hospitals allow legal action compared with 61% of non-340B hospitals. In very high cancer prevalence hospitals, the proportions are 72% versus 52%, respectively. The difference in the subset of hospitals with policies permitting legal action between 340B and non-340B hospitals is greater among very high cancer prevalence hospitals (20 percentage points) than among high cancer prevalence hospitals (14 percentage points), which shows that disparities in debt collection policies between these types of hospitals intensify at higher cancer burden (**Figure 2a**).

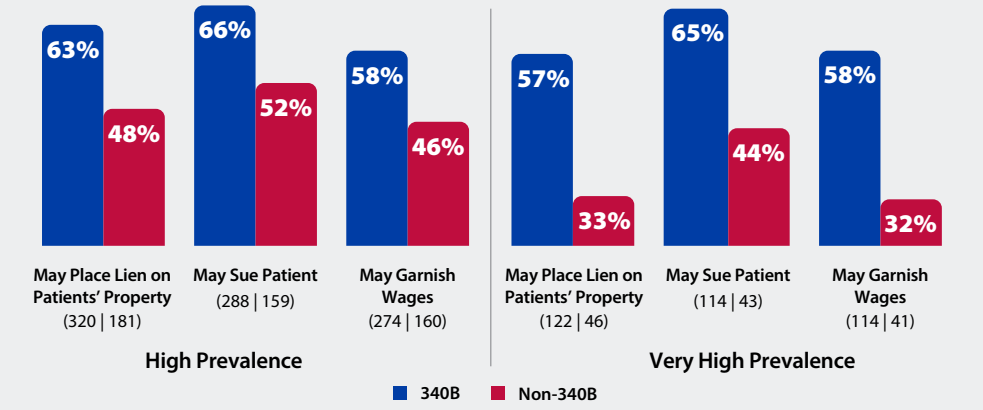
Figure 2a: Comparison of Hospitals That May Take Legal Action by 340B Status and Cancer Prevalence



Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

A similar pattern appears across specific legal actions, including liens, lawsuits, and wage garnishment, with 340B hospitals more likely to allow each practice than non-340B hospitals (**Figure 2b**). Legal action medical debt policies at 340B hospitals were consistent across hospitals with high (58% to 66%) and very high cancer burdens (57% to 65%). In contrast, non-340B hospitals were less aggressive in their legal action policies at hospitals with a very high cancer burden (32% to 44%) compared to those with a high cancer burden (46% to 52%) (**Figure 2b**). This demonstrates a consistent tendency for 340B hospitals to permit these legal actions at higher rates, regardless of cancer prevalence in the communities they serve.

Figure 2b: Comparison of Legal Action Medical Debt Practices by 340B Status and by High and Very High Cancer Prevalence



Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

Implications

These findings highlight a set of important implications for policymakers and patient advocacy organizations. First, although 340B hospitals are intended to serve as safety-net institutions, many continue to maintain debt collection policies that expose low-income and medically vulnerable patients to financial hardship. This exposure is even more concerning in oncology-heavy settings where continuity of care and timely treatment are essential.

Second, financial strain caused by aggressive collection practices may disrupt care. Patients managing cancer treatment who fear debt, lawsuits, or damaged credit may delay or avoid follow-up appointments and ongoing monitoring, risking poorer health outcomes.

Finally, the evidence points to a structural misalignment within the 340B program. While the program is intended to enhance access and affordability for underserved patients, many participating hospitals continue to have debt collection practices that compound financial hardships and may impede treatment and recovery. This contradiction demands policy attention, including transparent reporting requirements and clearer expectations to ensure that 340B program benefits contribute directly to reducing and not exacerbating the financial burdens of the populations the program is meant to serve.

Policy Recommendations

- Improve and expand provider financial assistance programs, including through enhanced financial assistance screening and transparent billing
- Establish enforceable charity care requirements for 340B hospitals to ensure savings from the program are appropriately reinvested into services that benefit vulnerable patients
- Incentivize Medicaid expansion in states that have not yet expanded
- Support federally qualified health centers rendering no or low-cost services, including preventive care and cancer screenings, to low-income patients
- Prohibit aggressive debt practices at 340B hospitals, including banning care denial subsequent to existing medical debt
- Prohibit the transfer of spousal medical debt
- Consider proposals to reduce medical debt for patients at both the state and federal levels
- Exclude medical debt from credit decisions

Methodology

The following datasets were used for this analysis: Lown Institute Hospital Financial Assistance, Billing, and Collection Policy Dataset (current as of 9/30/25),[8] national open claims database (dates of service from July 1, 2022, to June 30, 2025), Health Resources and Services Administration (HRSA)'s 340B Office of Pharmacy Affairs Information System (OPAIS) database (current as of 7/1/25),[9] Centers for Medicare and Medicaid Services (CMS) Hospital General Information database (current as of 7/16/25),[10] CMS Inpatient and Outpatient Provider Specific Data (last modified July 2025),[11] and CMS Hospital Enrollments File (last modified September 2025).[12]

Medical debt collection information was sourced from the Lown Institute's research on hospitals' financial assistance, billing, and debt collection policies and practices. As of September 2025, this database includes information on 2500 hospitals compiled from publicly available online policy information and verified, when possible, through direct outreach to each hospital. Numbers in this analysis may differ from the first because the dataset was expanded to 2500 hospitals, compared with 1250 in the original analysis. The data have evolved due to a combination of factors, including data completeness, evolving reporting by hospitals, and changing debt collection practices. This study cannot verify the extent to which each of these factors contributed to the updated results. If a hospital has a policy but states that it does not take action, then it was classified as not having the practice. All percentages were rounded to the nearest whole number.

Cancer prevalence for each hospital was estimated using a national open claims database and defined as the proportion of patients treated for cancer within a hospital's overall patient population during the study period. Hospitals with at least 100 patients were included and grouped into four cancer prevalence categories: low, moderate, high, and very high. The very high category represented the top 10th percentile, and the remaining hospitals were evenly distributed among the other three categories.

Limitations

There are several limitations to this study. This analysis includes only approximately 40% of US hospitals.[13] While the initial data collection had been completed, the Lown Institute continuously maintains the database and updates the data as hospital medical debt collection practices change over time. Another limitation is that percentages represent only hospitals with available or verified information for the particular medical debt policy reported. Hospitals missing information for a category were excluded from that calculation, even though they might use specific policies. One important distinction is that the findings indicate whether hospitals maintain policies that allow debt collection actions, not how frequently those policies are enforced. For more information about the Lown Institute's research and data collection methodology, please see the Lown Institute's "Hospital Billing and Collection Practices, a National Data Set" website.[14]

Citation

National Consumers League. January 2026. *Hospital Medical Debt: Aggressive Debt Collection Practices in 340B Hospitals Despite Higher Cancer Burdens*. [Issue Brief].

References

1. https://nclnet.org/wp-content/uploads/2025/05/NCL-Medical-Debt-and-340B-National-Survey.pdf **2.** https://www.fightcancer.org/sites/default/files/medical_debt_factsheet_5-9-24_update.pdf **3.** https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf **4.** https://healthcostinstitute.org/all-hcci-reports/drug-administration-shifted-toward-outpatient-departments-especially-to-340b-hospitals/ **5.** Legal action includes placing liens on homes, filing lawsuits, and garnishing wages. In the Lown Institute research, if a hospital's medical debt policy included taking any legal action, then the follow-up policies around liens, lawsuits, and wage garnishment were reviewed. **6.** Differences in counts and percentages compared with the original issue brief are due to an expanded and updated dataset; the current analysis includes 2500 hospitals, whereas the initial brief was based on 1250. The data have evolved due to a combination of factors, including data completeness, evolving reporting by hospitals, and changing debt collection practices. This study cannot verify the extent to which each of these factors contributed to the updated results. **7.** Cancer prevalence reflects the proportion of patients treated for cancer based on a national open claims database. Hospitals with at least 100 patients were grouped into four tiers; "very high" represents the top 10%, with the rest evenly divided among low, moderate, and high. **8** https://lownhospitalsindex.org/report-hospital-financial-assistance-and-debt-collection-policies **9.** https://340bopais.hrsa.gov/home **10.** https://data.cms.gov/provider-data/dataset/xubh-q36u **11.** https://www.cms.gov/medicare/payment/prospective-payment-systems/provider-specific-data-public-use-sas-format **12.** https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-enrollments **13.** https://www.aha.org/statistics/fast-facts-us-hospitals **14.** https://lownhospitalsindex.org/report-hospital-financial-assistance-and-debt-collection-policies

Analysis conducted by Magnolia Market Access.