SPECIAL EDITION

PR

PATIENTS RISING

MEDICAL DEBT IS DRIVING FAMILIES INTO COURT

SIDE EFFECTS MAY INCLUDE

BANKRUPTCY

THE HIDDEN COSTS OF THE AMERICAN HEALTHCARE SYSTEM

FROM THE FOUNDER

No One Should Consider It A Financial Risk to Seek Medical Care in America

Americans don't enter hospitals to gamble with their financial future, yet bankruptcy court filings across the country tell a consistent story.

Medical debt appears consistently in consumer bankruptcy filings across the United States. These records reflect a recurring pattern in which illness generates financial obligations that extend well beyond the point of care, shaped by coverage gaps, opaque pricing, and prolonged billing practices. Rather than functioning as a discrete financial event, medical costs become embedded in household insolvency, revealing how the structure of healthcare financing places sustained financial exposure on patients.

This pattern warrants attention where it intersects with the federal 340B Drug Pricing Program. Created by Congress in 1992, the program lowers drug acquisition costs for hospitals and clinics serving vulnerable populations. Its statutory framework assumes that institutional savings will translate into patient benefit. The law, however, places little emphasis on how those savings are used and establishes few mechanisms for oversight or accountability.

Within that framework, hospitals face no statutory obligation to pass 340B savings directly to patients, reduce charges, or publicly disclose how program revenue is allocated. Federal audits occur infrequently, and reporting requirements remain narrow in scope. Oversight largely

depends on institutional discretion rather than enforceable standards tied to patient outcomes.

The effects of this structure appear in bankruptcy courts. Filings show patients treated at nonprofit hospitals, including those participating in 340B, carrying significant medical debt into insolvency proceedings. Medical bills surface alongside wages, housing obligations, and basic household expenses, often functioning as the tipping point that renders recovery impossible. These records offer documentation rather than anecdote, illustrating how financial exposure persists even within systems designed to serve as safety nets.

This divergence between program intent and patient experience reflects a policy design that prioritizes institutional flexibility over measurable patient protection.

Transparency mechanisms capable of tracing savings to patient benefit remain limited. Accountability structures linking participation in 340B to reductions in patient financial harm remain largely absent.

Medical bankruptcy emerges from this environment as a predictable outcome of policy choices embedded in statute, regulation, and enforcement. Court filings capture the downstream effects of those choices with clarity. Patients bear the financial consequences of care delivered within a system that externalizes risk while retaining benefit.

Programs created in the name of patient protection require evaluation based on patient outcomes. Until such evaluation becomes standard, bankruptcy will continue to function as a routine endpoint of medical care, recorded in courtrooms after treatment has ended.

Yours in Advocacy,

Terry Wilcox

Terry Wilcox
Co-Founder and Chief Mission Officer
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HOW MEDICAL DEBT BREAKS A HOUSEHOLD

BANKRUPTCY FILINGS TELL WHAT HAPPENS AFTER THE HOSPITAL VISIT ENDS

On paper, the finances of a couple living in Camano, Washington appeared stable. Their income covered housing, utilities, transportation, and daily expenses, and their household carried no unusual consumer debt. That balance shifted after medical bills from regional hospital systems accumulated to more than $32,000, pushing the couple into bankruptcy court, according to filings in the Western District of Washington.

The debt arose from care provided by Skagit Regional Health, Kaiser Permanente, and Providence Health & Services. Each system participates in the federal 340B Drug Pricing Program, a policy created more than three decades ago to support hospitals and clinics serving low-income and medically vulnerable populations. Congress established the program in 1992 amid concerns that rising drug costs were placing safety-net providers under increasing financial strain, threatening their ability to maintain services for patients with limited means.

Under the program, qualifying hospitals are permitted to purchase certain outpatient medications at prices significantly below standard market rates. The savings generated through those discounts accrue to the institution and are intended to strengthen its capacity to deliver care, particularly to patients who rely on public insurance or lack the ability to pay. Over time, participation in the program expanded, especially among nonprofit and regional hospital systems, including many across Washington state.

As hospital systems in Washington consolidated and broadened their outpatient footprints, 340B participation became integrated into larger care networks that included hospital-owned clinics, specialty practices, and pharmacies. Discounted drug purchasing became one component of a complex financial structure that supports care delivery across urban, suburban, and rural communities. The program's design assumes that lowering institutional costs will ease financial pressure on hospitals and, in turn, reduce the burden on patients receiving care.

That assumption operates indirectly. Federal law specifies which hospitals may participate and how drug prices are calculated, but it leaves broad discretion over how resulting savings are used. Hospitals are not required to apply discounts to patient bills, adjust charges associated with care, or publicly account for how 340B revenue is allocated. Oversight focuses largely on eligibility compliance rather than on patient-level financial outcomes.

In the Camano case, court records show the couple was billed standard rates for care despite receiving services from hospitals benefiting from discounted drug purchasing. Their bankruptcy filing reflects medical charges layered onto routine household expenses, followed by collections activity and legal pressure. The documents do not suggest business losses or discretionary spending, but rather financial exposure tied directly to medical treatment.

Washington state has enacted charity care laws intended to shield low-income patients from excessive hospital bills, requiring providers to offer free or discounted care to eligible individuals. In practice, eligibility depends on income thresholds, documentation, and patient awareness, and advocates say many families encounter these protections only after balances have grown or accounts have entered collections.

Federal law specifies which hospitals may participate and how drug prices are calculated, but it leaves broad discretion over how resulting savings are used.

Across Washington, hospital systems continue to expand facilities, acquire physician practices, and invest in new service lines while benefiting from federal programs designed to support care delivery. At the same time, bankruptcy filings in the state continue to show medical debt as a recurring contributor to household insolvency. These records provide a view into how healthcare costs intersect with personal finances after care has been delivered and billing cycles have run their course.

For the couple in Camano, medical bills functioned as the decisive factor that tipped their household into insolvency, according to court filings. Their case reflects a broader dynamic within the healthcare system, where institutional financial relief does not consistently translate into protection from patient-level financial harm.

As policymakers revisit the structure and scope of the 340B program, bankruptcy records such as this one offer a grounded account of how the program operates in practice. The court filings capture what occurs when a policy designed to strengthen access to care relies on institutional discretion rather than enforceable safeguards for the patients it was meant to serve.

MEDICAL DEBT IN BANKRUPTCIES

The table shows medical debt amounts listed in Washington bankruptcy filings from 2024 where hospital systems are named as creditors. Totals reflect patient-reported debt in court records and do not represent hospital billing totals or statewide figures.

Hospital System	Medical Debt Listed (USD)	Medical Debt Listed (USD)
Providence Health & Services	$430,000+	Y
Virginia Mason Franciscan Health	$385,000+	Y
PeaceHealth	$305,000+	Y
Skagit Regional Health	$275,000+	Y
MultiCare Health System	$255,000+	Y
UW Medicine (incl. Harborview, UW Medical Center)	$240,000+	Y
Samaritan Healthcare	$155,000+	Y
Confluence Health	$125,000+	Y
Kadlec / Providence Kadlec Regional	$200,000+	Y
EvergreenHealth	$65,000+	Y
WhidbeyHealth	$55,000+	Y
Arbor Health	$85,000+	Y
Seattle Children's Hospital	$25,000+	Y
Grays Harbor Community Hospital	$55,000+	Y
Other / Non-340B or Out-of-State Hospitals	$150,000+	Mixed

CONGRESS SHOULD MAKE 340B WORK FOR PATIENTS

It shouldn't just work for hospital profits.

Congress has spent years debating the size and scope of the 340B program, but what it has avoided is the harder question.

Why does a program that delivers billions in discounted revenue to hospitals operate with no federal requirement that patients see any financial relief?

The federal 340B Drug Pricing Program was created with a clear purpose to allow hospitals and clinics serving low-income and medically vulnerable patients to stretch limited resources and maintain access to care, but more than thirty years later, the program has grown into a multibillion-dollar system that operates with little federal oversight and few requirements tying institutional benefit to patient affordability.

Congressional attention to the issue has been building. In recent months, the Senate Health, Education, Labor and Pensions Committee convened a hearing to examine the scope and impact of the 340B program, focusing on its rapid expansion and the absence of clear evidence that savings reach patients. That hearing followed the release of an extensive report by Senator Bill Cassidy, the committee's chair, which raised concerns about transparency, accountability, and whether the program continues to function as Congress originally intended.

"The investigation revealed that a significant share of 340B revenue goes to for-profit middlemen and that patients do not always realize direct benefits from the program," Sen. Cassidy said during the hearing. "And let's point out, the growth of the 340B program is causing patients to pay more now for prescription drugs than ever before.

Supporters of the status quo often argue that institutional savings benefit patients indirectly by stabilizing hospital finances and supporting community services. That logic has guided the program's expansion, particularly among large hospital systems

with extensive outpatient networks, yet neither federal statute nor regulation requires hospitals to demonstrate how those financial advantages improve affordability or access for the patients receiving care.

The Senate HELP Committee hearing emphasized this tension. Witnesses and lawmakers pointed to the program's growth and the lack of consistent data showing that patients experience lower costs as a result of 340B discounts. Sen. Cassidy's report similarly questioned whether the program's structure aligns with its original intent, noting that hospitals face few obligations beyond eligibility compliance and record-keeping.

Without federal standards, the program relies heavily on institutional discretion. Hospitals decide how savings are allocated, whether they fund charity care, offset operational costs, or support unrelated investments. Patients, meanwhile, continue to encounter high drug prices, large bills, and mounting medical debt, even when care is delivered by hospitals benefiting from discounted purchasing and other public advantages.

This disconnect has real consequences. Medical debt continues to surface in bankruptcy court filings across the country, including cases tied to nonprofit and safety-net hospitals that participate in 340B. Those records offer a stark reminder that institutional financial strength does not necessarily translate into patient financial security. Congress has the authority to establish reporting requirements that show how 340B savings are used, to link discounted drug pricing to patient affordability, and to require hospitals to demonstrate tangible patient benefit as a condition of participation. Previous reform proposals have outlined pathways for transparency and accountability, but what has been missing is the political will to move them forward.

The 340B program remains an important component of the healthcare safety net. Preserving it does not require leaving it unregulated. On the contrary, thoughtful federal oversight would strengthen the program by ensuring that its benefits reach the patients Congress sought to protect in 1992. After months of hearings, reports, and public scrutiny, Congress has both the evidence and the opportunity to act.

How to Write to You Congressional Memeber

- **Open by stating that you are a constituent** and where you live so the office immediately knows the message is relevant to them.
- **Clearly state your position** in the first two sentences so staff can categorize your message quickly.
- **Use one specific example** from your own experience to show how the issue affects patients in real terms.
- **Keep the message brief**, ideally three short paragraphs, so it can be read and summarized efficiently.
- **Write in plain language** and avoid policy jargon so your point is clear to staff and lawmakers alike.
- **Ask for one concrete action**, such as supporting oversight or opposing a provision, rather than multiple requests.
- **Stay focused on patient cost and access**, which are the issues lawmakers hear most often from constituents.
- **Maintain a respectful, professional tone** to keep the message credible and effective.
- **Close with a brief thank-you** to acknowledge the staff's time and attention.

PATIENTS RISING

Empowering every patient in America to advocate for reforms placing them, alongside their doctors, in control of their healthcare choices.

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