Legal Division Docket Manager
Consumer Financial Protection Bureau
Comment Intake—2024 NPRM FCRA
Medical Debt Information
1700 G Street NW
Washington, DC 20552

August 12, 2024

Re: Prohibition on creditors and consumer reporting agencies concerning medical information (Regulation V) Docket No. CFPB-2024-0023/RIN 3170-AA54

To whom it may concern:

Americans for Financial Reform Education Fund (AFREF) and the Center for Responsible Lending (CRL) appreciate the opportunity to comment on the Consumer Financial Protection Bureau's (CFPB) notice of proposed rulemaking to remove medical debt from credit reports and prohibit consumer reporting agencies from sharing medical debt information with creditors..[1] AFREF is a nonpartisan and nonprofit coalition of more than 200 civil rights, consumer, labor, business, investor, faith-based, and civic and community groups dedicated to advocating for policies that shape a financial sector that serves workers, communities and the real economy, and provides a foundation for advancing economic and racial justice that includes the impact of bank resiliency on the economy, communities, consumers, and small businesses. CRL is a non-profit, non-partisan research and policy organization dedicated to protecting homeownership and family wealth by working to eliminate abusive financial practices. CRL is affiliated with Self-Help, one of the nation's largest nonprofit community development financial institutions.

AFREF and CRL support the proposed rule which amends the Fair Credit Reporting Act Regulation V to prohibit creditors and consumer reporting agencies from using medical debt information for credit eligibility determinations or providing medical debt information that a creditor is prohibited from using. The Fair Credit Reporting Act was enacted, in part, to "improve the accuracy and integrity of consumer reports."[2] Medical debt is not an accurate predictor of an individual's ability to repay debts[3] and should not be considered in credit underwriting decisions.

The rule can and should be strengthened to extend the credit reporting prohibition to medical lending products used to pay down medical debts (medical credit cards) and to prohibit the use of medical debt reports for other determinations beyond credit eligibility, including at a minimum employment and tenant screening.

The proposed rule is essential to protect families from the negative impacts of medical debt on their health and their finances. But the rule is especially important to protect Black, Latine, and other

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[1] Consumer Financial Protection Bureau (CFPB). Notice of Proposed Rulemaking. Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V). 89 Fed. Reg. 118. June 18, 2024 at 51682 et seq.

[2] *Ibid.* at 51686.

[3] VantageScore. "Impact of VantageScore Credit Scores Due to Changes in Medical Debt Collection Information Reporting." August 2022 at 4.

people of color who are more likely to have medical debt burdens. These medical debts and their negative consequences are substantially rooted in a historical and ongoing legacy of structural racism in housing, employment, and healthcare policies and practices that contribute to racial economic inequality, racial gaps in health insurance coverage, and inequities in health care access and health conditions. The proposed rule will not remedy these inequities, as it does not address the causes of the wide racial disparities in the prevalence of medical debt. But it is essential to prevent the negative outcomes of medical debt from perpetuating these racial inequities in future financial determinations — the ability to secure credit, apply for a job, or get an apartment.

The scale, impact, and racial inequities of medical debt

People accrue medical debt when they lack the financial resources to pay for medical care. Today, 15 million consumers have medical debt collections on their credit reports that average at least $3,100.[4] Families with more modest income, lower household wealth, no or inadequate health insurance coverage, higher medical needs, and less access to local, affordable, quality health care can easily accumulate medical debt from medical expenses that are unaffordable. Nearly 140 million people in the United States have faced medical financial hardship because of out-of-pocket health care bills.[5]

The financial burden of medical debt can erode savings, cause families to cut back on essential expenses such as food, cause stress and anxiety, negatively impact credit scores, and more.[6] The consequences can be dire. A 2019 study found that two-thirds of U.S. bankruptcies were related to medical expenses or medical-related work loss — over 500,000 medical bankruptcies annually.[7]

Structural racism and institutional practices have imposed a far higher medical debt on Black, Latine, and other people of color.[8] The discriminatory federal, state, and local housing, employment, and health care policies and programs — alone and in combination — contributed to Black and Latine families having lower incomes and household wealth, greater health care needs, less insurance coverage, and less access to affordable, quality care that leads to higher levels of medical debt.

Black families are nearly twice as likely to have medical debt as white families and Latine families are 14 percent more likely (Black 13 percent, Latine 8 percent, and white 7 percent).[9] These figures are likely an underestimate based solely on medical debt in collections. More than 40 percent of families — half of Black and Latine families (56 percent and 50 percent, respectively) — report outstanding medical bills on credit cards or owed to family members as well as medical debt in collections.[10] These medical debts burden household finances. A 2022 survey by the Commonwealth Fund found

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[4] Sandler, Ryan and Zachary Blizard (Sandler and Blizard 2024). Consumer Financial Protection Bureau. "Recent Changes in Medical Collections on Consumer Credit Records." March 2024 at 3 to 4.

[5] Yabroff, K. Robin et al. "Prevalence and correlates of medical financial hardship in the USA." *Journal of General Internal Medicine*. Vol. 34. 2019.

[6] Lopes, Lunna et al. (Lopes et al. 2022). KFF. "Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills." June 16, 2022.

[7] Himmelstein, David U. et al. "Medical bankruptcy: Still common despite the affordable care act." *American Journal of Public Health*. Vol. 109, No. 3. March 2019 at 431 to 433.

[8] This analysis focuses on Black and Latine people and families largely because of the lack of comparable data across all variables, but information on Indigenous, Asian, immigrant people and families is included where available.

[9] Rakshit, Shameek et al. (Rakshit et al. 2024). KFF. "The Burden of Medical Debt in the United States." February 12, 2024.

[10] Lopes et al. 2022.

that half of Black and Latine families struggled to pay medical bills or medical debt and one in eight had medical debt over $4,000.[11] More than half of Black and Latine (52 percent and 56 percent, respectively) families reported spending all or most of their savings to afford paying their medical debt.[12]

The financial and health impacts for families of color can be severe. Medical debts are the most common reason debt collectors contact people.[13] These debt collections, lawsuits and judgments, and wage garnishments are 60 percent more common in communities of color than white communities, due to systemic and historical discrimination in financial services, housing, employment, and the criminal justice system.[14] Medical debt can harm families' credit scores and constrain their ability to secure credit. Credit scoring often replicates the systemic racial biases of the financial system because the Black and Latine consumers with lower incomes, more medical debt, lower homeownership rates, fewer assets, and less credit history are deemed less creditworthy.[15] Black and Latine consumers that have credit scores tend to have lower average credit scores than white consumers (8 percent and 5 percent lower, respectively) and subprime credit scores are concentrated in Black, Latine, and Native communities.[16]

Medical debt also feeds a self-perpetuating cycle of racial health inequities, as families with medical debt burden may put off medical appointments and health care treatments to avoid piling on additional medical debt. One in seven people with medical debt report being denied care because of outstanding medical bills.[17] This can lead to worsening health conditions and potentially more expensive treatments and even more medical debt, further burdening Black and Latine families.

The racial disparities in medical debt reflect racial inequities in health insurance coverage, access to affordable and quality health care in communities of color, yawning racial income and wealth gaps, and significant racial inequities in the prevalence of illnesses. The roots of medical debt for Black and Latine families are largely found in structural racism. The continuing impacts of decades of racially biased and discriminatory federal and state policies have led to higher medical debts and collections for Black and Latine families.

Federal labor laws that entrenched occupational segregation for Black workers (and now Black, Latine, and immigrant workers, especially women) have not only lowered earnings and wealth building capacity for workers of color, they have limited access to employer-based health insurance coverage, which makes medical debt more likely. Federal housing policies redlined Black and Latine communities and cemented residential segregation patterns that persist decades after federal civil rights laws made these discriminatory policies illegal. The residential segregation and racial economic stratification mean these Black, Latine, and immigrant communities have fewer local medical

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[11] Collins, Sarah R, Lauren A. Haynes, and Belebohile Masitha (Collins, Haynes, and Masitha 2022). Commonwealth Fund. "Findings from the Commonwealth Fund Biennial Health Insurance Fund." 2022 at Table 5.

[12] Lopes et al. 2022.

[13] CFPB. "Consumer Experiences with Debt Collection." January 2017 at 21.

[14] Breno Braga et al. Urban Institute. "Local Conditions and Debt in Collections." June 2016.

[15] National Consumer Law Center. "Past Imperfect: How Credit Scores and Other Analytics 'Bake In' and Perpetuate Past Discrimination." May 3, 2016.

[16] Sandberg, Erica. "How race affects your credit score." *US News and World Report*. August 9, 2022; Urban Institute. "Credit Health During the COVID-19 Pandemic." March 8, 2022.

[17] Lopes et al. 2022.

providers and less access to affordable quality care but also face added health burdens from environmental pollutants and underinvestment in their communities. Federal and state health laws have further hindered access to health care facilities and health care coverage that has bolstered a two-tier health care system where Black and Brown families often have less health care coverage and less access to quality health care facilities and systems.

Structural racist policies individually and in combination contribute to the higher levels of medical debt for Black and Latine families. The ongoing legacy of persistent redlining and residential segregation reduces household and generational wealth building capacity, undermines access to health care, and contributes to higher levels of chronic health problems. Occupational segregation reduces household earnings and the chance that workers and families have employer-based health insurance. Federal health care investments have underfunded healthcare systems in Black and Latine neighborhoods and federal and state implementation of health programs have excluded many people of color or offered second-tier coverage. Layered on top of the government sanctioned structural barriers are the explicit and implicit biases of providers that further create access barriers for people of color.

Redlining and residential segregation increase economic inequality and health inequities

Long-standing structural racism in residential housing — redlining, mortgage discrimination, environmental injustice, food deserts, and more — contribute to racial economic inequality and racial health inequities for Black, Latine, and Native families. Federal, state, and local racial exclusion policies, restrictive covenants that prohibited home sales to people of color, home lending and housing discrimination, and violence created and enforced racially segregated communities that continue to exist more than a half a century after the enactment of the Fair Housing Act.

Federal housing policies implemented in the 1930s substantially drove residential segregation and disinvestment that lowered access to credit, suppressed home values and intergenerational wealth accumulation, and contributed to racial economic inequality. The federal Home Owners Loan Corporation drew red lines on more than 200 city maps that explicitly designated Black, Latine, and immigrant neighborhoods high-risk for home lending (hence redlining) and the Federal Housing Administration refused to insure mortgages in non-white neighborhoods.[18] Federal loans after World War II fueled the development of the suburbs but explicitly excluded Black families.[19] Redlined neighborhoods continue to have higher concentrations of people of color and higher concentrations of lower-income families.[20] Between 1934 and 1962, the Federal Housing Administration backed $120 billion in mortgage loans, but because of the FHA's race-based policies, less than 2 percent of the loans went to Black, Latine, Asian, or Native families.[21] A 2020 Federal

[18] Aaronson, Daniel, Daniel Hartley, and Bhashkar Mazumder (Aaronson, Hartley, and Mazumder 2020). Federal Reserve Bank of Chicago. "The Effects of the 1930's HOLC 'Redlining' Maps." White Paper No. WP 2017-12. August 2020; Turner, Margery Austin and Solomon Greene. Urban Institute. "Causes and Consequences of Separate and Unequal Neighborhoods." 2020.

[19] Loh, Tracy Hadden, Christopher Coes, and Becca Buthe. Brookings Institute. "The Great Real Estate Reset." December 16, 2020.

[20] Mitchell, Bruce and Juan Franco. National Community Reinvestment Coalition. "HOLC 'Redlining' Maps: The Persistent Structure of Segregation and Economic Inequality." March 20, 2018.

[21] Bailey, Nikitra. National Fair Housing Alliance. "Boom and Bust: The Need for Bold Investments in Fair and Affordable Housing to Combat Inflation." Testimony before the Committee on Financial Services. U.S. House of Representatives. December 1, 2022 at 3.

Reserve Bank of Chicago study found that redlined communities had far lower homeownership rates and lower home values, reducing the homeownership wealth building opportunities by 40 percent from 1950 to 1980.[22]

The disinvestment, lower homeownership rates, and lower levels of economic activity in segregated neighborhoods are associated with lower income levels, lower educational attainment levels, and lower household wealth.[23] In 2022, typical Black and Latine families had lower incomes (about 44 percent lower) and far lower household net worth (about 80 percent lower) than typical white families according to Federal Reserve data.[24] The gap between Black and white wealth today is essentially the same as it was before the civil rights movement — a depressing failure to make progress on economic equality.[25] Medical debt represents a significant share of typical household income for Black and Latine families. The $3,100 medical debt burden would represent nearly 6 percent of the Black median household income ($53,500) and nearly 5 percent of the Latine median household income ($62,800) in 2022.[26]

Residential segregation contributes to poor health conditions and inequitable access to health care. Families in segregated communities are exposed to more pollutants, have less access to healthy foods, and get fewer opportunities for exercise.[27] A 2023 study found that Black children in redlined neighborhoods had significantly higher lead levels than white children living outside of redlined neighborhoods.[28] Discriminatory local zoning and land use policies have encouraged the siting of polluting industries in or near redlined communities of color and lower-income areas that further entrenches residential segregation and worsens the environmental burdens that harm human health.[29] Many communities of color lack affordable and quality health care providers, which creates a barrier to accessing timely care and treatment.[30] People living in redlined communities continue to

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[22] Aaronson, Hartley, and Mazumder 2020.

[23] Turner, Margery Austin and Solomon Greene. Urban Institute. "Causes and Consequences of Separate and Unequal Neighborhoods." 2020.

[24] Federal Reserve Board. Survey of Consumer Finances 2022. Before Tax Median Family Income and Median Household Net Worth. 2023.

[25] Kuhn, Moritz, Moritz Schularick, and Ulrike I. Steins. CESifo. "Income and Wealth Inequality in America, 1949-2016." Working Paper No. 6608. June 2018.

[26] U.S. Census Bureau. "Income in the United States, 2022." September 12, 2023 at Table A-2.

[27] Rabin, Roni Caryn. *New York Times*. "Racial inequities persist in health care despite expanded insurance." August 17, 2021.

[28] Karp, Robert J. "Redlining and Lead Poisoning: Causes and Consequences." *Journal of Health Care for the Poor and Underserved*. Vol. 34, No. 1. February 2023.

[29] U.S. Commission on Civil Rights. "Environmental Justice: Examining the Environmental Protection Agency's Compliance and Enforcement of Title VI and Exec. Order 12,898." September 2016; Wilson, Adrian et al. NAACP, Indigenous Environmental Network, Little Village Environmental Justice Organization. "Coal Blooded: Putting Profits Before People." November 2012; Mohai, Paul and Robin Saha. "Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies." *Environmental Research Letters*. Vol 10. December 2015; Saha, Robin and Paul Mohai. "Historical context and hazardous waste facility siting: Understanding temporal patterns in Michigan." *Environmental Studies Faculty Publications Paper*. Paper 1. 2005.

[30] Gaskin, Darrell J. et al. "Residential segregation and disparities in healthcare services utilization." *Medical Care Research and* Review. Vol. 69, No. 2. April 2012; Radley, David C. et al. Commonwealth Fund. "Advancing Racial Equity in U.S. Health Care." April 18, 2024.

have inequitable healthcare access and worse health outcomes, such as higher asthma-related emergency room visits from historically redlined Black and Latine neighborhoods.[31]

The combination of lower incomes, lower household wealth, and poorer health conditions and health care access has contributed to higher levels of medical debt in segregated communities. Urban Institute research has documented that people who live in communities of color — especially Black communities — are more likely to have medical debt in collections.[32] The CFPB found that even after credit reporting bureaus voluntarily removed some medical debt from credit reports starting in 2022, families with medical collections still on their credit reports were more likely to live in predominantly Black or Latine census tracts and lower-income census tracts.[33]

Occupational segregation contributes to racial economic inequality and racial health insurance gaps

The racial gap in income, wealth, and insurance coverage — all of which are closely associated with medical debt — is based in part on federal labor statutes dating to the New Deal. The Fair Labor Standards Act, governing hours and wages among other things, and the National Labor Relations Act, granting workers the right to form unions, intentionally excluded agricultural workers, domestic workers, and tipped workers to deny Black workers — especially Black women — the critical workplace protections and economic opportunity and maintain the racial exploitation of Black workers.[34] These exemptions segregated Black workers into low-wage, low-benefit occupations that have suppressed Black family wealth-building opportunities and excluded many Black workers from employer-based health care.[35]

Congress has slowly amended these statutes to narrow these exemptions, but some vestiges of these exemptions remain (farmworkers are ineligible for overtime, tipped workers have a far lower minimum wage, many domestic workers are still excluded from minimum wage and overtime protections).[36] And people of color continue to make up sizable majorities of these segregated and low-wage occupations that lack some basic worker protections and frequently lack employer-based health insurance. These occupations exemplify the broader occupational segregation of Black and Latine workers into lower-wage, lower-benefit, higher-precarity jobs that contribute to racial economic inequality and higher uninsurance rates.

More than half of domestic workers are women of color (22 percent Black, 29 percent Latine, and 6 percent Asian) who earn median wages of $12 an hour, far below the national $20 an hour median

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[31] National Academies of Science, Engineering, and Medicine. *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care on Optimal Health for All*. Washington, DC: National Academies Press. 2024 at 55

[32] Santillo, Miranda et al. Urban Institute. "Communities of Color Disproportionately Suffer from Medical Debt." October 14, 2022.

[33] Sandler and Blizard 2024 at 2 and 8.

[34] Dixon, Rebecca (Dixon 2021). National Employment Law Project. "From Excluded to Essential: Tracing the Racist Exclusion of Farmworkers, Domestic Workers, and Tipped Workers from the Fair Labor Standards Act." Testimony before the Workforce Protections Subcommittee, Education and Labor Committee. U.S. House of Representatives. May 3, 2021 at 3.

[35] Yearby, Ruqaiijah, Brietta Clark, and José F. Figueroa. "Structural Racism in Historical and Modern US Health Care Policy." *Health Affairs*. Vol. 41, No. 2. February 2022.

[36] Dixon 2021 at 12 to 15.

wage.[37] People of color make up the majority of many low wage tipped occupations, including the $16 an hour car wash workers (20 percent Black, 34 percent Latine, and 3 percent Asian), the $16 an hour non-restaurant food servers (19 percent Black, 25 percent Latine, and 7 percent Asian), and the $15 an hour cafeteria attendants and barbacks (10 percent Black, 33 percent Latine, and 5 percent Asian).[38] People of color still make up the majority of farmworkers today. Three-quarters of farmworkers are Latine, 9 percent are Native, and 3 percent are Black, and they earned $18 an hour in 2023, about one-third less than the non-farm non-supervisory wage of $28 an hour.[39]

Occupational segregation is a driving factor in substantially higher uninsurance rates for people of color that contributes to medical debt

Health insurance is the primary payer of medical expenses and the lack of health insurance is a significant driver of medical debt. Families that were uninsured or only had partial insurance coverage were nearly three times as likely to have medical debt as families that had continuous health insurance (8.5 percent and 2.9 percent, respectively).[40] The racial gaps in insurance coverage are well known. A 2021 study found that even after controlling for income, race "was independently associated with lack of insurance" and that low-income people of color in poorer health were 68 percent less likely to have health insurance than high-income white people in good health.[41] Occupational segregation has long shunted people of color into more precarious jobs with lower pay and lower benefits, including health insurance coverage, making medical care more unaffordable and leading to medical debt.

Black, Latine, and Native people are far less likely to have employer-sponsored health insurance than white people. In 2023, more than two-thirds (68.4 percent) of white people had employer-sponsored health insurance, compared to half (52.6 percent) of Black people, and about two-fifths of Latine and Native people (43.0 and 39.6 percent, respectively).[42] The occupations that were carved out of federal labor law and are disproportionately filled by Black and Latine workers still have far higher levels of uninsurance. The uninsurance rate for all workers was 11.2 percent in 2014, but 16.7 percent of domestic housecleaners, 19.3 percent of restaurant servers, and 65 percent of farmworkers were uninsured.[43]

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[37] Wolfe, Julia et al. Economic Policy Institute. "Domestic Workers Chartbook." May 14, 2020 at 1 and 7.

[38] Over 1.1 million workers are covered by occupational code 53-7061 cleaners of vehicles and equipment, 35-3041 food servers, non-restaurant, 35-9011 dining room and cafeteria attendants and bartender helpers. U.S. Bureau of Labor Statistics. "National Occupational Employment and Wage Estimates." May 2023; BLS. "Employed Persons by Detailed Occupation, Sex, Race, and Hispanic or Latino Ethnicity." January 26, 2024.

[39] Fung, Wenson et al. JBS International for U.S. Department of Labor. "Findings from the National Agricultural Workers Survey (NAWS) 2021-2022." Research Report No. 17. September 2023 at 8 to 9; U.S. Department of Agriculture. Farm Labor Survey. Wage Rate by Type by Year, U.S. 1993-2023. Accessed August 2024.

[40] Bennett, Neil et al. (Bennett et al. 2021). U.S. Census Bureau. "19% of U.S. households could Not afford to pay for medical care right away." April 7, 2021.

[41] Lee, De-Chih, Hailun Liang, and Leiyu Shi. "The convergence of racial and income disparities in health insurance coverage in the United State." *International Journal for Equity in Health*. Vol. 20. April 7, 2021.

[42] Claxton, Gary, Matthew Rae, and Aubrey Winger. KFF. "Employer Sponsored Health Insurance 101." May 28, 2024.

[43] Boal, Winifred L, Jia Li, and Aaron Sussell. Centers for Disease Control and Prevention. "Health insurance coverage by occupation among adults aged 18-64 years—17 states, 2013-2014." *Morbidity and Mortality Weekly Report*. Vol. 67, No. 21. June 1, 2018 at 595 and 597; Lueck, Sarah and Matt Broaddus. Center on Budget and Policy Priorities. "Expanding Skimpy Health Plans is the Wrong Solution for Uninsured Farmers and Farmworkers." July 17, 2018.

The high levels of uninsurance for workers of color in low-wage, low-benefit jobs, combined with the inequitable state expansion of Medicaid under the Affordable Care Act, significantly raises the overall uninsurance rates for people of color. As a result, people of color are significantly less likely to have health insurance than white people. Black people have uninsurance rates 43 percent higher than white people (7 percent and 10 percent, respectively); Latine and Native people have uninsurance rates over 150 percent higher (18 percent and 19 percent, respectively).[44] And larger shares of Black and Latine people were uninsured for at least part of the year (26 percent and 32 percent, respectively).[45] Nearly one-third (32 percent) of non-citizens were uninsured in 2022 and uninsurance rates were four times higher for Latine people who were non-citizens and twice as high for Black and Asian people who were non-citizens.[46]

Systemic racism in federal health policies and health inequities undermine affordable health care access and exacerbate medical debt

Families with lower incomes, less insurance coverage, greater medical needs, and less access to affordable quality care have more medical debt. The structural racism in housing and employment policies contributes to racial health inequities and worse health outcomes, lower incomes, and lower household wealth, making it harder to afford the greater medical need, leading to greater medical debt. Federal and state health care policies, programs, and investments have explicitly and implicitly diverted resources away from Black, Latine, and other communities of color, worsening access to affordable quality health care and increasing racial health inequities.

Federal investments and funding in public health facilities have long starved hospitals and clinics in Black and Latine communities of needed capital and operating revenues necessary to provide access to healthcare. The 1946 Hill-Burton Hospital Survey and Construction Act aimed to shore up public health capacity in underserved lower-income and rural areas but was embedded with legally enforced segregation that left communities of color out of the largest public investment in hospitals in U.S. history. That legacy continues to contribute to worse health outcomes today.[47] Hospitals only desegregated after the passage of the Medicare program threatened to withhold funds from segregated facilities in 1966.[48]

The 1960 Medicaid precursor Kerr-Mills Medical Assistance to the Aged provided support for indigent seniors' health care, but the program was adopted and administered by the states and only 3 percent of beneficiaries were in states with half the U.S. Black population (Alabama, Arkansas, Georgia, Florida, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas).[49]

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[44] Figures for non-Medicare eligible people. Ndugga, Namba, Latoya Hill, and Samantha Artiga (Ndugga, Hill, and Artiga 2022). KFF. "Key Data on Health and Health Care by Race and Ethnicity." June 11, 2024.

[45] Collins, Haynes, and Masitha 2022 at Table 1.

[46] Sharer, Breanna and Gideon Lukens. Center for Budget and Policy Priorities. "Health Coverage Rates Vary Widely Across and Within — Racial and Ethnic Groups." May 9, 2024.

[47] Appelbaum, Eileen, Emma Curchin and Rosemary Batt (Appelbaum, Curchin, and Batt 2024). Center for Economic and Policy Research. "Structural Determinants of Health: Hospitals' Unequal Capital Investments Drive Health Inequities." July 24, 2024.

[48] Rabin, Roni Caryn. *New York Times*. "Racial inequities persist in health care despite expanded insurance." August 17, 2021.

[49] Nolan, LaShyra T., Adam L. Beckman, Emma Sandoe. "Medicaid's history reinforced rather than eliminated racial health disparities." *Health Affairs*. September 1, 2020; U.S. Census Bureau. "Race of the Population of the United States by States: 1960." No. PC(S1)-10. September 7, 1961.

Similarly, the states that have not implemented Medicaid expansion, which provides more federal support for providing Medicaid health insurance coverage to working families up to 138 percent of the poverty line, include more than one-third (37 percent) of the Black population (Alabama, Georgia, Florida, Mississippi, South Carolina, Tennessee, and Texas).[50]

Medicare reimbursement formulas and other changes to the federal tax code under-supported hospitals with higher proportions of uninsured or Medicaid patients, which compromised the financial viability of hospitals in lower-income areas — especially Black, Native, and immigrant communities — making it harder for these health systems to access the needed financing to make upgrades, harming health care access in these areas.[51] Recent studies have found that urban hospital closures are more prevalent in Black neighborhoods and rural hospital closures are more common in counties with higher Black and Latine populations.[52] And Medicaid provider and hospital reimbursement rates are so low that many providers refuse to participate, which creates a segregated health care system for low-income people of color that effectively discriminates against Black and Latine Medicaid enrollees.[53]

Neighborhood and occupational segregation contribute to racial health inequities that increase medical debt

Redlining and residential segregation contribute substantially to racial health inequities that increase the prevalence of health conditions, lower incomes needed to pay for medical care, and reduce access to affordable quality care. A 2023 *Journal of General Internal Medicine* study concluded that "historical redlining is linked to increased risk of diabetes, hypertension, and early mortality due to heart disease with evidence suggesting it impacts health through suppressing economic opportunity."[54] The occupational segregation of Black, Latine, and immigrant workers into lower-paid, physically demanding, and hazardous jobs contributes to racial health inequities.[55]

The racial gaps in insurance coverage, residential segregation, and access to care contribute to racial disparities in the prevalence of chronic disease — especially undiagnosed conditions — that adds to medical costs and medical debt. Black, Latine, and Asian people are far more likely to have diabetes than white people (29 percent, 15 percent, and 24 percent, respectively) and are much more likely to

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[50] KFF. "Status of State Medicaid Expansion Decision: Interactive Map." May 8, 2024; Centers for Disease Control and Prevention. "Single-Race Population Estimates 2020-2022 by State and Single Year Age Request." Accessed August 2024.

[51] Appelbaum, Curchin, and Batt 2024.

[52] Tung, Elizabeth L. et al. "Associations of U.S. hospital closure (2007-2018) with area socioeconomic disadvantage and racial/ethnic composition." *Annals of Epidemiology*. Vol. 92. April 2024; Planey, Arrianna Marie et al. North Carolina Rural Health Research Program. "Since 1990, Rural Hospital Closures Have Increasingly Occurred in Counties that Are More Urbanized, More Diverse, and Economically Unequal." March 2022.

[53] MALDEF. [Press release]. "Advocates file lawsuit alleging California's separate and unequal Medi-Cal system violates the rights of millions." July 12, 2017.

[54] Egede, Leonard E. et al. "Modern day consequences of historic redlining: Finding a path forward." *Journal of General Internal Medicine*. Vol. 38, No. 6. May 2023.

[55] Steege, Andrea L. et al. "Examining occupational health and safety disparities using national data: A cause for continuing concern." *American Journal of Industrial Medicine*. Vol. 57, No. 5. May 2014; Landsbergis, Paul A., Joseph G. Grzywacz, and Anthony D. LaMontagne. "Work organization, job insecurity, and occupational health disparities." *American Journal of Industrial Medicine*. Vol. 57, No. 5. May 2014.

have undiagnosed diabetes (74 percent, 62 percent, and 100 percent, respectively).[56] Black, Latine, and Asian people are over 17 percent more likely to have high blood pressure than white people, but more than 16 percent less likely to have their high blood pressure under control.[57] Black, Latine, Asian, and Native people are less likely to receive cancer screenings and research suggests that people of color receive later-stage diagnoses for some cancers than white people.[58]

Black and Latine adults (aged 45 to 64) are also more likely to have disabilities than white adults (35.5 percent, 35.5 percent, ad 26.6 percent, respectively) and receive less equitable access to needed healthcare.[59] These disparities are more pronounced for Black and Latine women.[60] The occupations where workers have the highest incidence of disability are also the occupations excluded from New Deal Labor laws that continue to have high concentrations of Black and Latine workers — food serving, housecleaning, and personal care and service.[61] And, people with disabilities are nearly twice as likely to have medical debt as the overall population (13 percent and 8 percent, respectively).[62]

The cost of care is a significant barrier to care. People of color are substantially more likely to avoid necessary health care because of costs, in part reflecting higher levels of uninsurance and racial economic gaps. Black, Latine, and Native people were far more likely to go without healthcare than white people, according to a 2022 KFF survey (14 percent, 21 percent, 16 percent, and 11 percent, respectively).[63] A 2021 *Journal of the American Medical Association* study found that from 1999 to 2018, the racial gaps in health care affordability, and in the population in poor or fair health, did not change even when controlling for income levels.[64] Black and Latine people were about 50 percent more likely to be in poor or fair health than whites.[65] People who report their health as fair or poor are far more likely to owe medical debt than those who report their health as good or better (14 percent, 20 percent, and 10 percent, respectively).[66] Moreover, the lack of local, affordable, quality providers and adequate transportation create additional barriers to care. A 2022 *Journal of American Medical Association* study found that Black and Latine patients also faced significantly higher non-economic barriers to access health care than white patients and reported long wait times and difficulty getting to providers.[67]

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[56] CDC. "National Diabetes Statistics Report." May 15, 2024.

[57] Aggarwal, Rahul et al. "Prevalence, Awareness, Treatment, and Control in the United States, 2013 to 2018." *Hypertension*. Vol. 78, No. 6. August 9, 2021.

[58] Tong, Michelle, Latoya Hill, and Samantha Artiga. KFF. "Racial Disparities in Cancer Outcomes, Screening and Treatment." February 3, 2022.

[59] Holliman, Brooke Dorsey. "Disability doesn't discriminate: Health inequities at the intersection of race and disability." *Frontiers of Rehabilitation Science*. Vol. 4. July 6, 2023.

[60] Sternfeld, Barbara et al. "Understanding racial/ethnic disparities in physical performance in midlife women: Findings from SWAN (Study of Women's Health Across the Nation)." *Journal of Gerontology, Psychological Sciences, and Social Sciences*. Vol. 75, No. 9. August 14, 2019.

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In addition, the explicit and implicit bias of health care providers and the health care system creates a racial barrier to access health care. People of color are far more likely to report that their health care provider treated them unfairly because of their race than white people: Black patients were six times more likely to report unfair treatment than white patients (18 percent and 3 percent, respectively), Latine and Native patients were four times more likely (11 percent, 12 percent), and Asian patients were three times more likely (10 percent).[68] The implicit bias of physicians and nurses (identified by perceptions of unfair treatment) leads to poorer health and poorer health outcomes for Black and Latine patients.[69] This is consistent with a Commonwealth Fund study that found that white people receive better quality healthcare than Black, Latine, or Native people.[70]

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The proposed medical debt rule would provide needed protections for families from the unfair inclusion of medical debt information in credit eligibility considerations. This protects everyone from being denied credit because they have medical debt, but it is an essential protection for Black, Latine, and other people of color who are more likely to have medical debt because of a confluence and combination of structural racism in housing, employment, and health care policies and programs. The proposed rule does not alleviate these racial inequities but it does prevent them from being further amplified in future credit eligibility determinations. The CFPB should expand the scope of the proposed rule to prohibit medical debt information from being used in any other determinations, especially for employment and rental applications, to prevent any medical debt reports from exacerbating racial economic inequities.

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