Medical Debt Fell during the Pandemic. How Can the Decline Be Sustained?

Michael Karpman, Kassandra Martinchek, and Breno Braga
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People often incur medical debt when they receive bills they cannot afford to pay from hospitals, doctors' offices, or other health care providers. Providers may be willing to negotiate a lower bill, offer financial assistance to reduce the amount owed, or develop a payment plan. However, these options are not always available or sufficient for protecting people from incurring debt, which can take the form of a balance owed to providers or a credit card payment or loan. The shares of adults with problems paying medical bills and past-due medical debt in collections declined as the economy recovered from the Great Recession and the major health insurance coverage provisions of the Affordable Care Act (ACA) took effect (Cohen and Zammitti 2017; Kluender et al. 2021). But limited research has examined trends in medical debt in the wake of the COVID-19 pandemic's extensive economic and health impacts.[1]

In this brief, we examine the prevalence of medical debt and provide the first national estimates of changes in the share of adults with medical debt following the onset of the pandemic using two complementary data sources: (1) the Urban Institute's Health Reform Monitoring Survey (HRMS), a nationally representative survey of adults ages 18 to 64, and (2) Urban Institute credit bureau data, a nationally representative panel of deidentified, consumer-level records from a major credit bureau. We use 2018–21 data from the HRMS to estimate the share of nonelderly adults reporting they or their families have medical bills that they are paying off over time (hereafter called "medical debt") and the share reporting problems paying family medical bills in the past 12 months. We also use 2018–21 credit bureau data to estimate the share of adults with credit bureau records who have medical debt in

collections. Focusing on multiple measures allows us to capture different aspects of the nation's medical debt challenges, including the stock of debt accumulated over many years as well as recent difficulties paying medical bills. For both data sources, we highlight prepandemic trends and focus on changes between the data collection period immediately before the pandemic and the most recent data collection period. We find the following:

- After holding steady in the years before the pandemic, the shares of adults with medical debt, problems paying medical bills in the past 12 months, and medical debt in collections have declined since the pandemic began.

  » In April 2021, 16.8 percent of nonelderly adults reported medical debt, down from 23.6 percent in March 2019. The share reporting problems paying family medical bills in the past 12 months also fell from 17.0 to 12.2 percent over the same period.
  » The share of adults with credit records who have medical debt in collections fell from 15.3 percent in February 2020 to 13.9 percent in August 2021.

- The share of adults with medical debt in collections is highest among those ages 25 to 34, but this share declined for all age groups following the onset of the pandemic.

  » In August 2021, adults ages 25 to 34 had the highest rate of medical debt in collections at 18.0 percent. Adults ages 65 and older were the least likely to have medical debt in collections (7.8 percent), followed by adults ages 18 to 24 (11.2 percent).
  » Adults in all age ranges have experienced reductions in both self-reported medical debt and medical debt in collections since the pandemic began. The reduction in self-reported medical debt was greatest among adults ages 18 to 34.

- Though medical debt declined across racial and ethnic groups, inequities persisted in 2021.

  » Black adults continued to report the highest rate of medical debt in April 2021, at 22.5 percent; this compares with 19.9 percent of Hispanic/Latinx adults and 15.5 percent of white adults. Black and Hispanic/Latinx adults were also more likely than white adults to have problems paying medical bills (17.1 percent and 15.9 percent versus 10.1 percent).
  » The share of adults with medical debt in collections in August 2021 was highest in majority-Black communities (22.7 percent), followed by majority–American Indian/Alaska Native communities (17.7 percent) and majority-Hispanic/Latinx communities (16.0 percent). Majority-white communities had the lowest share of adults with medical debt in collections (12.6 percent).

The declines in medical debt and problems paying medical bills during the pandemic could be due to many factors, including a reduction in health care use resulting from efforts to prevent coronavirus exposure, growth in Medicaid enrollment that protected many people from the cost of high medical bills (McMorrow et al. 2022), and pandemic relief measures that provided temporary financial assistance to households. The risk of acquiring medical debt may increase when health care use rebounds to prepandemic levels and the provisions of federal pandemic legislation that have contributed to Medicaid enrollment growth expire.

New health insurance reforms and other policies could sustain the recent decline in medical debt and further reduce its prevalence. Health insurance reforms that would improve health care affordability and reduce medical debt include

- closing the Medicaid coverage gap in states that have not adopted the ACA Medicaid expansion,

- extending the enhanced Marketplace subsidies under the American Rescue Plan Act,

- reducing cost-sharing requirements for Marketplace plans,

- making subsidized Marketplace plans available to people with access to employer-based coverage, and

- ensuring compliance with the ban on balance billing under the No Surprises Act.

Other potential approaches to protect people from medical debt include

- strengthening the regulation of hospital financial assistance policies and debt collection practices,

- increasing take-up of public benefits and tax credits, and

- helping families build savings for unexpected expenses.

Background: Why Does Medical Debt Matter?

Medical debt is increasingly understood to be an important social determinant of health (Mendes de Leon and Griggs 2021). In addition to facing damaged credit and less financial security, adults with medical debt are more likely to delay or forgo needed health care because of the cost and have difficulty paying for food, housing, and other basic needs, putting them at risk of worse health (Hamel et al. 2016; Rabin et al. 2020). Consumer debt is also associated with poor mental health (Richardson, Elliott, and Roberts 2013). Health problems requiring hospitalizations and other expensive treatments can in turn cause additional financial distress, possibly perpetuating a vicious cycle (Dobkin et al. 2018).

Medical debt is also among the foremost financial challenges confronting US households, accounting for more than half of all debt in collections that appeared on consumer credit records over the past several years; these collections balances totaled up to $140 billion in 2020 (CFPB 2022; Kluender et al. 2021). After attempting to collect payment, providers often refer past-due accounts to third-party collections agencies and, less commonly, sell them to debt buyers (CFPB 2022; Furey and Kelly 2019). Currently, medical debt in collections that providers, collection agencies, or debt buyers report to the national credit reporting agencies typically shows up on credit reports after it is 180 days past due and can remain on them for up to seven years.[2] Credit record data understate the prevalence of medical debt because they do not always identify the industry source of the debt or medical debt paid with credit cards or loans,[3] and providers do not always report past-due medical debt to the three national credit reporting agencies.

Disparities in medical debt by race and ethnicity reinforce racial wealth inequities and may contribute to inequitable health outcomes. Black and Hispanic/Latinx adults are more likely than white adults to report having medical bills they cannot pay, and disparities between Black and non-Black adults persist even among those with health insurance (Bennett et al. 2021; Perry et al. 2021).[4] In December 2020, 17 percent of adults living in communities of color had medical debt in collections, compared with 13 percent of adults in majority-white communities.[5] The prevalence of self-reported past-due medical debt and medical debt in collections is especially high in southern states, including many with large Black and Hispanic/Latinx populations; this partially reflects differences in health insurance coverage and state decisions not to expand Medicaid (Caswell and Waidmann 2019; Karpman and Caswell 2017; Kluender et al. 2021).[6]

In some states, adults with past-due medical debt also face increasingly aggressive debt collection practices that can intensify their financial challenges. Using data from court records, researchers, journalists, and advocates have drawn attention to the frequency with which hospitals sue patients for unpaid medical bills, which can result in wage and bank account garnishments or liens placed on homes (Bruhn et al. 2019; National Nurses United 2020).[7] One study found that hospital lawsuits against patients in Wisconsin increased 37 percent between 2001 and 2018, disproportionately affecting Black patients and those in low-income communities (Cooper, Han, and Mahoney 2021).

The pandemic raised fears that medical debt would rise sharply as people lost jobs and health insurance and hospitals treated a surge of patients infected with COVID-19.[8] But several factors likely mitigated the pandemic's effects on aggregate medical debt. The Families First Coronavirus Response Act of March 2020 prohibited states from disenrolling Medicaid beneficiaries during the public health emergency in return for a higher federal Medicaid matching rate. This provision contributed to substantial enrollment growth in Medicaid, which was larger than the decline in employer-based coverage during the pandemic and helped prevent an increase in the uninsurance rate (McMorrow et al. 2022). Because Medicaid enrollees face little or no cost sharing when they receive care, people who gained or maintained Medicaid coverage may have had greater protection from high medical bills than if they had been insured with private coverage or uninsured.

In addition, the strong federal economic response to the pandemic—including stimulus checks, expanded unemployment benefits, and eviction and student loan payment moratoria—provided many families with a buffer against hardship during the recession. Finally, in-person visits for health care unrelated to COVID-19 fell substantially as both patients and providers sought to limit the spread of the novel coronavirus (Gonzalez et al. 2021; Mehrotra et al. 2021). This may have limited people's exposure to high medical bills but at the cost of deferring needed care.

Results

Since the pandemic began, medical debt and medical bill problems have declined across all three of our measures:

- **Medical debt:** The share of nonelderly adults in the HRMS reporting they or their families currently have medical bills that they are paying off over time

- **Problems paying family medical bills:** The share of nonelderly adults in the HRMS reporting they or their families had problems paying or could not pay medical bills in the past 12 months

- **Medical debt in collections:** The share of adults ages 18 and older who have one or more medical debt collections tradelines on their credit reports
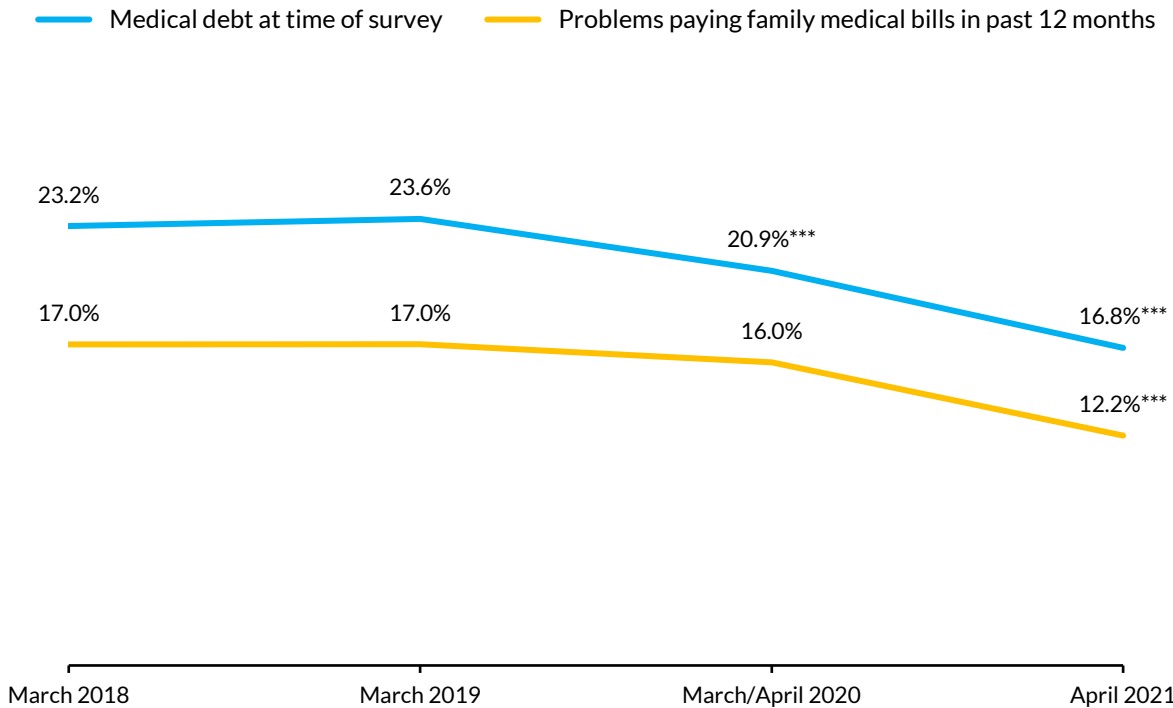
Because no single measure fully captures the nature and scope of medical debt, we examined trends for multiple outcomes that reflect the different ways in which people struggle to pay medical bills. For instance, adults reporting medical debt may have incurred the debt for care received in the past year or in previous years, and the debt may or may not be past due. Medical debt in collections only captures past-due debt in collections reported to credit bureaus and is a sign that families are experiencing financial distress. And though they represent families' current struggles to pay for medical costs, problems paying medical bills in the past 12 months may or may not result in medical debt, depending on whether charges are ultimately reimbursed by health insurance and whether providers decide to negotiate lower bills or provide financial assistance.

Between March 2019 and April 2021, the shares of nonelderly adults reporting medical debt and problems paying family medical bills in the past 12 months declined.

Trends in self-reported medical debt and problems paying medical bills were stable before the pandemic. The shares of nonelderly adults reporting medical debt were 23.2 percent in March 2018 and 23.6 percent in March 2019, and 17.0 percent of adults reported problems paying medical bills in both years (figure 1). Between March 2019 and April 2021, the share of nonelderly adults reporting medical debt declined from 23.6 to 16.8 percent, and the share reporting problems paying medical bills fell from 17.0 to 12.2 percent.

FIGURE 1

Shares of Adults Ages 18 to 64 Reporting Medical Debt and Problems Paying Family Medical Bills in the Past 12 Months, 2018 to 2021

——— Medical debt at time of survey ——— Problems paying family medical bills in past 12 months

23.2%   23.6%   20.9%***   16.8%***

17.0%   17.0%   16.0%   12.2%***

March 2018   March 2019   March/April 2020   April 2021

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Source: Health Reform Monitoring Survey, 2018–21.
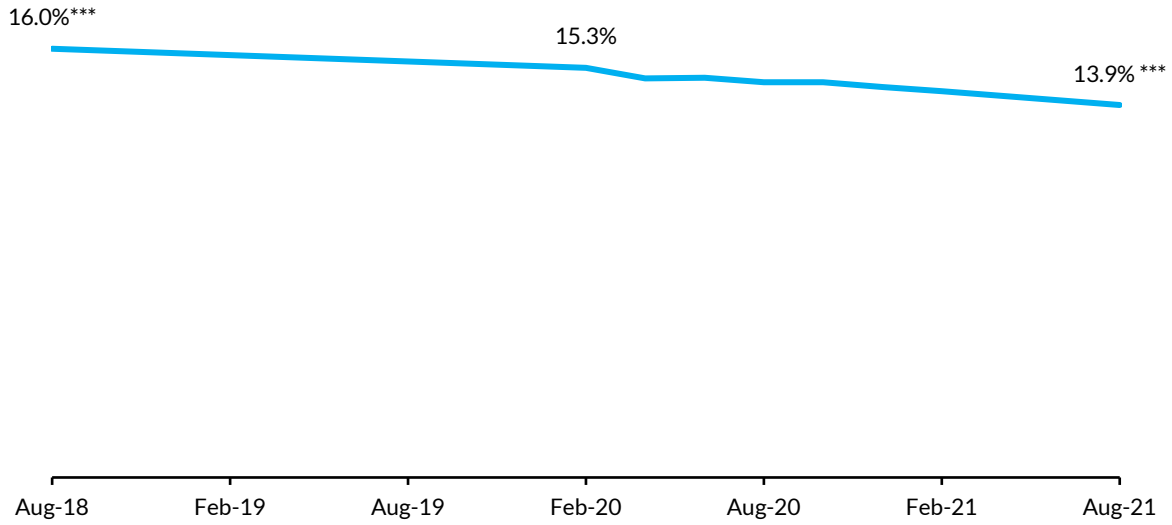**Notes:** Estimates are regression adjusted.
*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

The share of adults with credit records that have medical debt in collections has fallen significantly since February 2020.

The share of adults with medical debt in collections was already declining before the pandemic, and the reduction has accelerated since February 2020. Whereas 16.0 percent of adults had medical debt in collections reported in their credit records in August 2018, that share declined slightly to 15.3 percent in February 2020 (the month preceding the announcement of a national emergency due to COVID-19) and was 13.9 percent in August 2021 (figure 2). Among people with medical debt in collections, the median amount was $774 in August 2021, roughly the same as prepandemic medical debt amounts.[9]

FIGURE 2

Share of Adults Ages 18 and Older with Credit Records Who Have Medical Debt in Collections, 2018 to 2021

Source: Authors' tabulations of Urban Institute credit bureau data from 2018 to 2021.
Notes: Share with medical debt in collections is defined as the share of consumers with credit bureau records who have medical debt in collections.
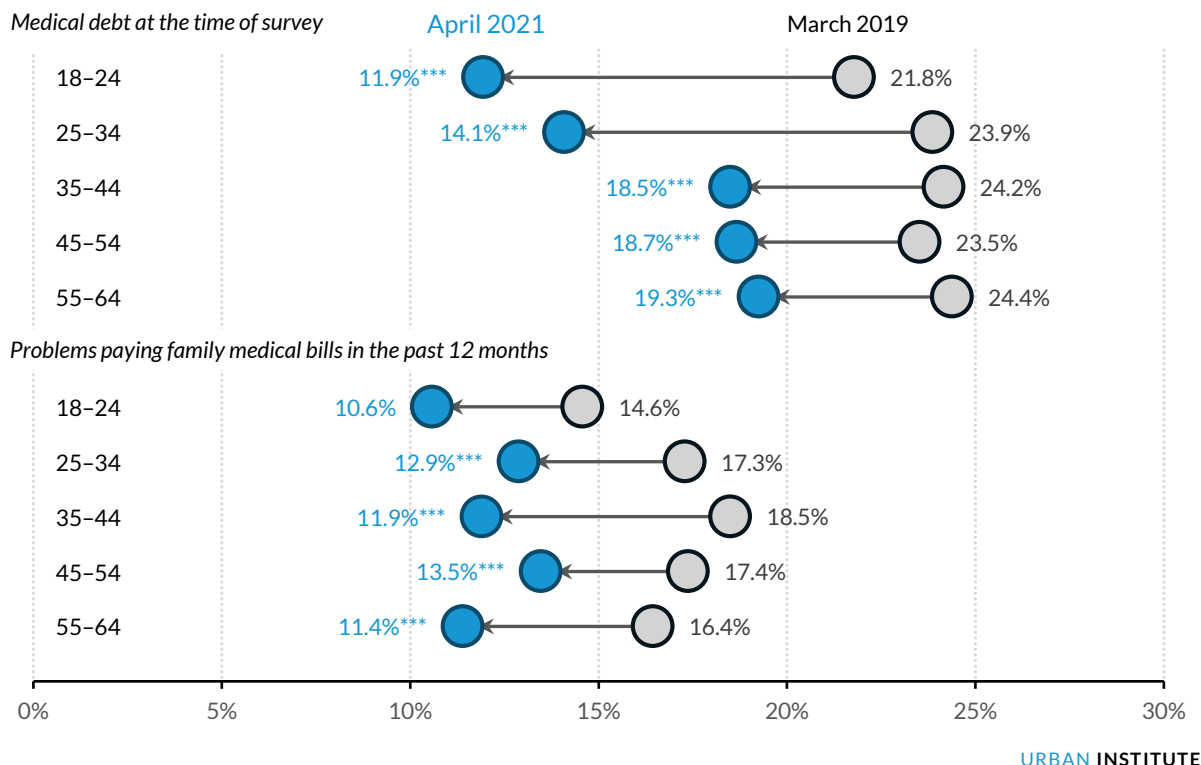*/**/*** Estimate differs significantly from that for February 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Younger adults remain more likely to have medical debt in collections than older adults. Reductions in self-reported medical debt and medical debt in collections occurred across age groups and were largest among young adults.

Before the pandemic, in March 2019, the share of nonelderly adults reporting medical debt varied little by age; such shares were approximately 24 percent among adults in each age group older than 24 and 22 percent among adults ages 18 to 24 (figure 3). We found more prepandemic variation by age in problems paying medical bills, ranging from 14.6 percent of 18-to-24-year-olds to 18.5 percent of 35-to-44-year-olds.

FIGURE 3

Shares of Adults Ages 18 to 64 Reporting Medical Debt and Problems Paying Family Medical Bills in the Past 12 Months, by Age, March 2019 and April 2021

Medical debt at the time of survey

April 2021   March 2019

Age	April 2021	March 2019
18–24	11.9%***	21.8%
25–34	14.1%***	23.9%
35–44	18.5%***	24.2%
45–54	18.7%***	23.5%
55–64	19.3%***	24.4%

Problems paying family medical bills in the past 12 months

Age	April 2021	March 2019
18–24	10.6%	14.6%
25–34	12.9%***	17.3%
35–44	11.9%***	18.5%
45–54	13.5%***	17.4%
55–64	11.4%***	16.4%

0%　5%　10%　15%　20%　25%　30%

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Source: Health Reform Monitoring Survey, March 2019 and April 2021.
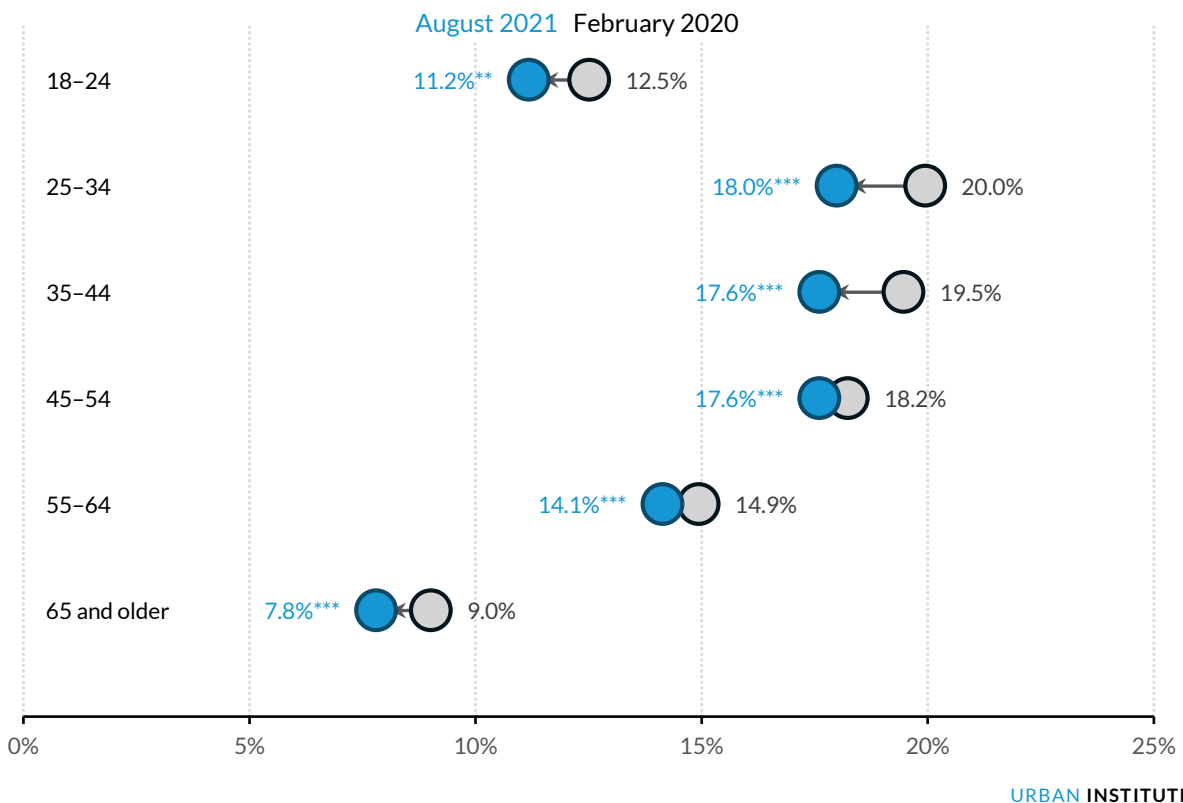**Notes:** Estimates are regression adjusted.
*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

Younger adults reported the largest declines in medical debt between March 2019 and April 2021. The share of 18-to-24-year-olds reporting medical debt fell about 10 percentage points, from 21.8 to 11.9 percent, and the share of 25-to-34-year-olds with medical debt declined by a similar margin, from 23.9 to 14.1 percent. In contrast, the share of adults with medical debt in each older age group fell by 5 to 6 percentage points. Reductions in problems paying medical bills were more uneven across the age distribution, and adults ages 35 to 44 experienced the largest decline (from 18.5 to 11.9 percent).

The share of adults with medical debt in collections has declined for all age ranges since the pandemic began. Just before the pandemic, in February 2020, the share of adults with medical debt in collections was relatively low among adults ages 18 to 24 (12.5 percent), highest among adults ages 25 to 34 (20.0 percent), and lowest among adults ages 65 and older (9.0 percent; figure 4). Notably, the youngest adults had higher rates of medical debt in collections than the oldest adults (12.5 versus 9.0 percent), despite adults ages 65 and older having much higher medical expenditures (Batty, Gibbs, and Ippolito 2018). These age differences partially reflect variation in access to health insurance coverage, including universal coverage through Medicare for elderly adults, and suggest young adults may need

more supports to buffer against medical debt (Caswell and Goddeeris 2020). Adults ages 25 to 34 experienced the greatest decline (2 percentage points) in the share with medical debt in collections, from 20.0 percent in February 2020 to 18.0 percent in August 2021. But adults in this age group continued to have the highest rate of medical debt in collections. Adults ages 35 to 44 and adults ages 18 to 24 experienced the next largest reductions (1.9 and 1.3 percentage points).

FIGURE 4

Share of Adults Ages 18 and Older with Medical Debt in Collections, by Age, February 2020 and August 2021

Source: Authors' tabulations of Urban Institute credit bureau data from February 2020 and August 2021.
Notes: Share with medical debt in collections is defined as the share of consumers with credit bureau records who have medical debt in collections.
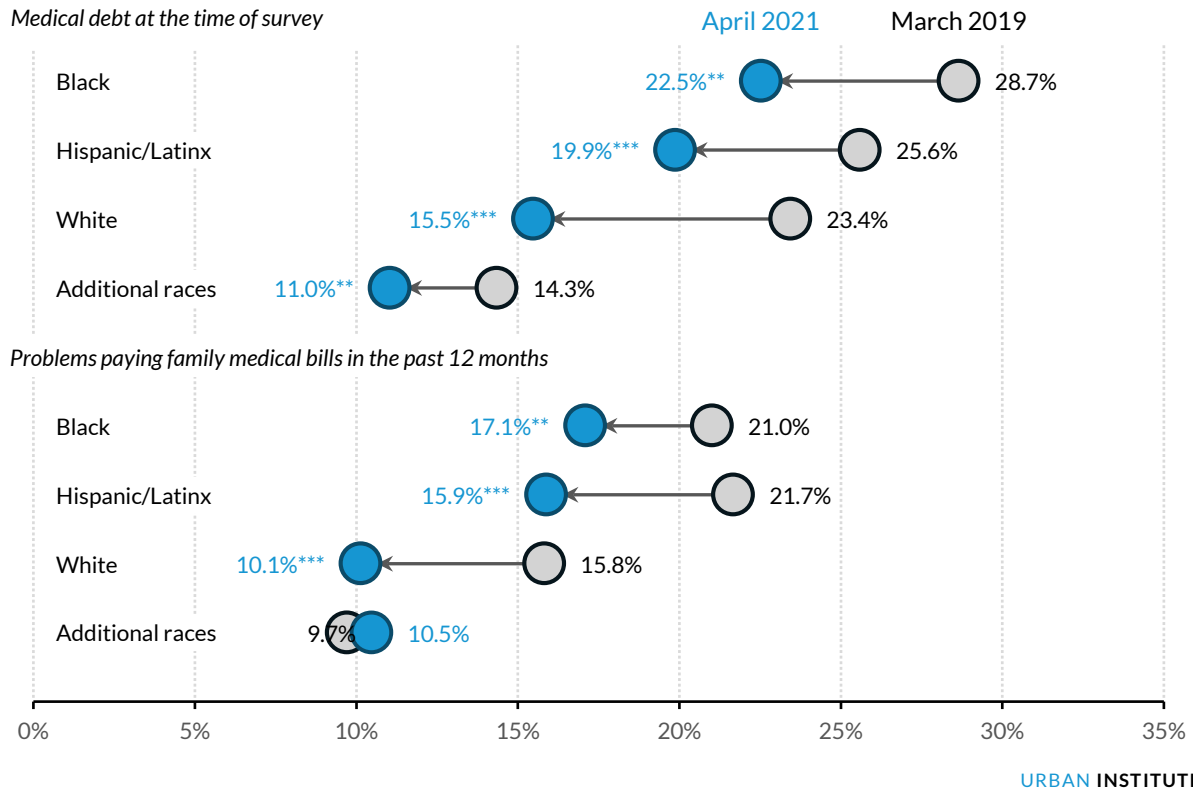*/**/*** Estimate differs significantly from that for February 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Though medical debt declined across racial and ethnic groups, inequities persisted in 2021.

Figure 5 shows that the share of nonelderly adults reporting medical debt fell between March 2019 and April 2021 for each racial and ethnic group we examined.[10] However, racial and ethnic gaps in medical debt persisted in both periods. In April 2021, Black adults were 7 percentage points more likely than white adults to report medical debt (22.5 versus 15.5 percent) and problems paying medical bills (17.1 versus 10.1 percent).[11] Hispanic/Latinx adults were also more likely than white adults to report medical

debt (19.9 versus 15.5 percent) and problems paying medical bills (15.9 versus 10.1 percent) in 2021. Just over 1 in 10 adults of additional races reported medical debt and problems paying medical bills during that period.

Shares of Adults Ages 18 to 64 Reporting Medical Debt and Problems Paying Family Medical Bills in the Past 12 Months, by Race and Ethnicity, March 2019 and April 2021

Medical debt at the time of survey

April 2021   March 2019

Race/Ethnicity	April 2021	March 2019
Black	22.5%**	28.7%
Hispanic/Latinx	19.9%***	25.6%
White	15.5%***	23.4%
Additional races	11.0%**	14.3%

Problems paying family medical bills in the past 12 months

Race/Ethnicity	April 2021	March 2019
Black	17.1%**	21.0%
Hispanic/Latinx	15.9%***	21.7%
White	10.1%***	15.8%
Additional races	9.7%	10.5%

0%   5%   10%   15%   20%   25%   30%   35%

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Source: Health Reform Monitoring Survey, March 2019 and April 2021.
Notes: Estimates are regression adjusted. Black and white adults are not Hispanic/Latinx. Adults of additional races are non-Hispanic/Latinx adults who are not Black or white or who are more than one race.
*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

Though the credit bureau data do not identify an adult's race or ethnicity, we can assess the racial and ethnic composition of residents in their zip code using data from the American Community Survey. Majority-Black communities experienced the greatest decline in the share of adults with medical debt in collections, from 25.0 percent in February 2020 to 22.7 percent in August 2021 (figure 6). The share of adults with medical debt in collections also declined in communities that are majority Hispanic/Latinx, American Indian/Alaska Native, and white, defined as zip codes where at least 60 percent of residents identify as members of one of these racial and ethnic groups.[12] Despite improvements in the share of adults with medical debt in collections across all groups during the pandemic, majority-Black and

majority–American Indian/Alaska Native communities continued to have the highest rates of medical debt in collections in August 2021 (22.7 and 17.7 percent).

Among those with medical debt in August 2021, residents in majority-Hispanic/Latinx communities had the highest median amount of medical debt in collections of about $884.[13] Median medical debt in collections has held steady for most communities during the pandemic, except for majority–American Indian/Alaska Native communities, whose median medical debt in collections declined from $934 in February 2020 to $797 in August 2021. Throughout the pandemic, majority-Black communities have had higher median amounts of medical debt in collections than majority-white communities ($794 versus $743 in August 2021). These racial and ethnic disparities reflect historical inequities that have reduced wealth, access to health insurance coverage, and economic choices for communities of color (Artiga et al. 2021; Kijakazi et al. 2019).

FIGURE 6
Share of Adults Ages 18 and Older with Credit Records Who Have Medical Debt in Collections, by Majority Racial or Ethnic Group in the Community, February 2020 and August 2021
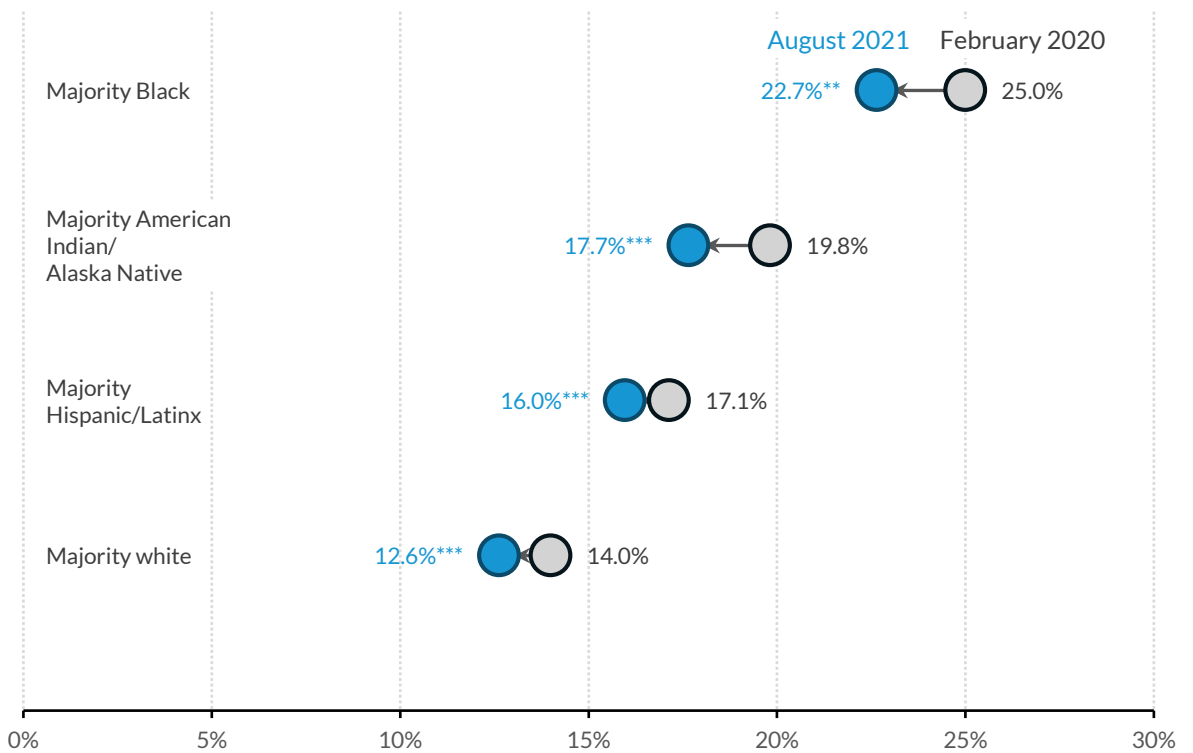
Source: Authors' tabulations of Urban Institute credit bureau data from February 2020 and August 2021.
Notes: Share with medical debt in collections is defined as the share of consumers with credit bureau records who have medical debt in collections.
*/**/*** Estimate differs significantly from that for February 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Despite significant job losses and hospitalizations for COVID-19, the prevalence of medical debt declined following the onset of the pandemic. This trend may partially reflect reduced health care use overall, as providers limited services and many patients avoided health care settings over concerns about coronavirus exposure (Gonzalez et al. 2021; Mehrotra et al. 2021). As of spring 2021, health care use had not recovered to prepandemic levels, and some adults were still delaying or forgoing needed care for themselves or their children over coronavirus exposure concerns (Gallagher et al. 2021; Gonzalez, Karpman, and Haley 2021a, 2021b).

Other factors may have mitigated the pandemic's impact on medical debt for more beneficial reasons. Anticipated increases in the uninsurance rate failed to materialize, as growth in Medicaid and Marketplace enrollment offset losses of employer-sponsored coverage, thereby protecting many people from expensive medical bills (McMorrow et al. 2022). Medicaid enrollees who would have otherwise been uninsured or privately insured may have received greater protection from high medical bills given the limited cost-sharing requirements in Medicaid.

Finally, financial relief measures have helped many households weather the pandemic recession. Evidence shows that broader measures of credit health such as credit scores and loan delinquency rates also improved during the pandemic's first year.[14] Many generous government relief measures including stimulus payments, expanded unemployment and nutrition benefits, and eviction and student loan payment moratoria have helped families pay their bills on time (An, Gabriel, and Tzur-Ilan 2021; Cherry et al. 2021).

However, most of the temporary pandemic relief measures have expired, and the freeze on Medicaid disenrollment instituted by the Families First Coronavirus Response Act will be lifted after the public health emergency ends. Without further policy action, the risk of medical debt may increase again as health care use rebounds and the remaining relief measures expire.

The three major credit reporting agencies' recent decision to remove most medical debt in collections from credit reports could mitigate the effects of medical debt on financial well-being.[15] Low credit scores can make it difficult for people to get mortgages and other forms of credit, cause them to pay higher interest rates and insurance premiums, and create barriers to renting a home and finding employment. Though newer credit scoring models place less weight on medical debt collections, removing most medical collections tradelines from credit reports means they will no longer affect a person's credit score (CFPB 2022). The Biden administration has also announced guidance to eliminate or limit medical debt as a factor in underwriting for federal credit programs, including US Department of Agriculture rural housing loans, Small Business Administration loans, and credit models used by Fannie Mae and Freddie Mac, and to eliminate the reporting of medical debt for veterans with bills from the Department of Veterans Affairs.[16]

Policies to Sustain the Decline in Medical Debt

The changes above could improve access to credit and economic opportunities but do not reduce the underlying debt owed to providers. The following health insurance reforms and other policy changes, however, could sustain the recent decline in medical debt, further reduce its prevalence over time, and reduce disparities by race, ethnicity, and age.

Closing the Medicaid coverage gap. Studies of Medicaid expansions before and under the ACA provide strong evidence that expanding Medicaid reduces medical debt in collections, bankruptcies, and other measures of financial distress by extending coverage to uninsured people (Brevoort, Grodzicki, and Hackmann 2018; Caswell and Waidmann 2019; Finkelstein et al. 2012; Gross and Notowidigdo 2011; Hu et al. 2018; Mazumder and Miller 2016). But in the 12 states that have not adopted the ACA's Medicaid expansion, more than 2 million uninsured adults with incomes below the federal poverty level fall into a coverage gap in which they do not qualify for Medicaid, but their incomes are not high enough to qualify for subsidized Marketplace coverage (Rudowitz, Garfield, and Levitt 2021); 59 percent of these adults are people of color and about half are young adults ages 19 to 34 (Garfield, Damico, and Rudowitz 2021; Lukens and Sharer 2021). Nearly 2 million more adults are currently eligible for Marketplace subsidies but would be eligible for Medicaid under the expansion. Closing the coverage gap would reduce racial disparities in coverage and medical debt and protect more young adults with low incomes from medical costs they cannot afford.

Extending enhanced Marketplace subsidies. For adults with incomes above the Medicaid eligibility threshold, extending the enhanced Marketplace premium tax credits authorized by the American Rescue Plan Act could secure recent increases in Marketplace enrollment (Buettgens, Banthin, and Green 2022). This law both reduced the share of income people must pay toward premiums and expanded eligibility for subsidies to people with incomes above 400 percent of the federal poverty level. Together, closing the Medicaid coverage gap and extending the enhanced Marketplace premium tax credits would increase the number of people with coverage by 7 million (Banthin, Simpson, and Green 2021). These policies would also lower the number of uninsured Black Americans by one-third, reducing racial disparities in coverage and potentially medical debt.

Reducing cost-sharing requirements in Marketplace plans. Though uninsured adults are more likely than insured adults to have medical debt, most adults with such debt incur it when they have insurance (Karpman and Long 2015). Options for making health care more affordable for people enrolled in ACA health insurance Marketplace plans include tying income-based premium subsidies to the price of gold plans (which cover 80 percent of the costs of covered services, on average, compared with the 70 percent actuarial value of silver plans) and increasing cost-sharing reductions for adults with low and moderate incomes (Blumberg et al. 2021).

Expanding access to Marketplace coverage for people with employer-offered health insurance. Further changes would be necessary to reduce medical debt for most people with employer-based coverage. Under the ACA, people are ineligible for Marketplace premium tax credits if they have an offer of coverage from an employer in which the employee premium contribution for the lowest-cost, self-only

plan (with a minimum actuarial value of 60 percent) is less than 9.61 percent of household income.[17] Many workers have difficulty affording the premiums and cost sharing for their employer plans, and the "firewall" between employer-offered coverage and Marketplace subsidies can make workers with low incomes worse off than if their employers did not offer coverage (Straw 2019). Eliminating this firewall would induce many workers to buy Marketplace coverage that is more affordable than their employer plans, but the trade-off would be increased federal spending (Blumberg, Holahan, and Zuckerman 2018).

Ensuring compliance with the No Surprises Act. New legislation that took effect in January 2022 will also reduce medical debt resulting from surprise medical bills by protecting patients who inadvertently receive out-of-network care for emergency services or for nonemergency services at in-network facilities. Before 2022, patients receiving treatment from out-of-network providers could be exposed to higher cost sharing and "balance bills" from providers for charges not covered by their health plans, though balance-billing protections varied across states. The No Surprises Act limits cost sharing to what patients would have paid for in-network care and prohibits balance billing.[18] State and federal enforcement will be important for ensuring compliance and reducing medical debt caused by surprise bills.[19]

Regulating hospital financial assistance and debt collection practices. Many hospitals use aggressive tactics to collect payment that can worsen the financial circumstances of economically vulnerable patients. One study found that more than a third of Virginia hospitals filed lawsuits against patients resulting in wage garnishments in 2017 (Bruhn et al. 2019). Moreover, nonprofit hospitals often file lawsuits, though they are required to provide charity care to patients with limited resources to maintain their tax-exempt status (Cooper, Han, and Maloney 2021). Despite this mandate, nearly half of nonprofit hospitals bill patients likely eligible for financial assistance.[20]

Efforts to raise awareness about medical debt collection practices have prompted states to regulate these practices and strengthen standards for charity care and nonprofit hospital community benefit spending (Stark and Bosco 2021). A new Maryland law increases the transparency of hospital lawsuits against patients, requires hospitals to adopt a financial assistance policy that includes determining eligibility for charity care at the time of service, prohibits hospitals from garnishing wages from patients eligible for charity care, and prohibits liens on homes stemming from hospital lawsuits.[21] Other states have limited interest rates on medical debt and have placed restrictions on selling medical debt to debt buyers (CFPB 2022).

Federal agencies are also taking new actions to protect patients. The Department of Health and Human Services recently announced plans to collect data from more than 2,000 health care providers on their financial assistance and debt collection practices, which it will use to guide policy, grantmaking, and enforcement decisions.[22] The Department of Veterans Affairs is streamlining its process for providing medical debt relief to veterans. And the Consumer Financial Protection Bureau is taking steps to investigate credit reporting companies and debt collectors that use aggressive and predatory strategies to collect medical debt.

Expanding access to public benefits and tax credits. As noted above, medical debt improved during the pandemic despite unprecedented job and income losses. This improvement coincided with an increase in personal savings rates, partially because of stimulus payments and other financial assistance provided through pandemic relief legislation.[23] Though most relief measures have expired, data on how families used this assistance suggest that expanding access to nonhealth benefits would improve financial stability. For instance, many adults whose households received advanced payments of the enhanced child tax credit reported using them to pay off debt or increase savings (Karpman et al. 2021). But some eligible households missed out on the payments, and rates of receipt were lowest among Hispanic/Latinx adults and adults who are American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or more than one race.

Establishing policies and programs that help families build savings. Other policies that could provide families with a stronger buffer against medical debt include relaxing asset limits on safety net programs to increase household savings and participation in mainstream financial markets (Ratcliffe et al. 2016) and establishing programs like matched savings accounts to help families build emergency savings and wealth (Azzolini, McKernan, and Martinchek 2020). To address persistent racial disparities in financial well-being, policymakers could explore investing in wealth building for communities through baby bonds or other targeted investments (Brown and McKernan 2021). Initiatives to reduce debt and increase savings could also be especially helpful for young adults, who have had greater difficulties building wealth than older generations (McKernan, Ratcliffe, and Shanks 2019).

Data and Methods

Health Reform Monitoring Survey

Launched in 2013, the Urban Institute's Health Reform Monitoring Survey is a nationally representative, internet-based survey of adults ages 18 to 64 that provides timely information on health insurance coverage, health care access and affordability, and other health topics before federal survey data become available. For each round of the HRMS, we draw a stratified, random sample of nonelderly adults from Ipsos's KnowledgePanel, the nation's largest probability-based online research panel. Members of the panel are recruited from an address-based sampling frame covering approximately 97 percent of US households, including those without internet access. If needed, panel members are given internet access and web-enabled devices to facilitate their participation.

For this analysis, we used data from the March 2018, March 2019, March/April 2020, and April 2021 rounds of the HRMS. Survey rounds in 2018 and 2019 had sample sizes of approximately 9,500 adults, including oversamples of adults with incomes below 138 percent of the federal poverty level. Changes to the survey's design in 2020 reduced the sample size to 9,000 adults, with larger oversamples of adults in low- and moderate-income households, nonwhite and Hispanic/Latinx adults, and young adults. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population, based on benchmarks from the Current Population Survey and the American Community Survey. Participants can take the survey in English or

Spanish, and the survey takes a median of 15 minutes to complete. The margin of sampling error, including the design effect, for the full sample of adults in the 2021 survey round is plus or minus 1.2 percentage points for a 50 percent statistic at the 95 percent confidence level.

We focus on two measures of medical bill problems and medical debt based on the following survey questions: The first is, "For this question, think about your and your family's health care experiences over the past 12 months, that is, since [current month] [previous year]. Did you or anyone in your family have problems paying or were unable to pay any medical bills?" The second is, "Do you or anyone in your family currently have any medical bills that are being paid off over time?" We refer to affirmative responses to the first question as "problems paying family medical bills in the past 12 months" and affirmative response to the second question as "medical debt."

Estimated changes in these outcomes are regression adjusted to control for any changes in the demographic and socioeconomic characteristics of respondents in each survey round not fully captured in the survey weights. This allows us to remove variation caused by changes in the observable characteristics of people responding to the survey over time. We control for measures used in the poststratification of both the KnowledgePanel and the HRMS, including gender, age, race and ethnicity, primary language, educational attainment, marital status, presence of children in the household, household income, family income, homeownership status, internet access, urban or rural residence, and region. We also control for citizenship status and participation in the previous round of the survey. In presenting the regression-adjusted estimates, we use the predicted rate of each outcome in each year for the same nationally representative population. For this analysis, we base the nationally representative sample on respondents to the 2020 and 2021 rounds of the survey.

The HRMS has several limitations, including a low cumulative response rate, and nonresponse bias is likely only partially mitigated by the survey weights. However, studies assessing recruitment for the panel from which HRMS samples are drawn have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008). Further, HRMS estimates benchmark well against federal surveys with larger samples sizes, higher response rates, and stronger designs (Long et al. 2014). We also find little change in nonresponse in the HRMS during the pandemic, though the impact of the pandemic on surveys is not yet fully understood. Self-reported problems paying medical bills in the past 12 months and medical debt are subject to measurement error, and survey responses do not indicate whether the debt is past due or if the respondent received financial assistance or negotiated a payment plan or lower bills with the provider.

Urban Institute Credit Bureau Data

The Urban Institute credit bureau panel contains annual waves of credit bureau data from August 2016 to August 2021. To better represent the financial well-being of adults during the pandemic, we updated the data every second month from February 2020 until February 2021. These data consist of a random 2 percent sample of deidentified adults from a major credit bureau (about 5.5 million adults). In August 2021, our last data point, we added another 2 percent sample of adults, representing about 11 million adults with credit records.

The credit bureau data have a few limitations. First, these data exclude information on roughly 11 percent of US adults with no credit file (Brevoort, Grimm, and Kambara 2015). Second, they do not contain adults' demographic and socioeconomic characteristics, such as race or ethnicity. To address the lack of such information, we enrich the data using the American Community Survey. We incorporate zip code–level information on the demographic and socioeconomic characteristics of locations where individuals live to assess differential effects across key groups. For example, from the American Community Survey we can obtain the shares of residents in a zip code tabulation area who are Black, Hispanic/Latinx, American Indian/Alaska Native, and white. Using the zip code of a residence from the credit bureau data, we can classify adults with a credit record as living in a majority-Black, majority-Hispanic/Latinx, majority–American Indian/Alaska Native, or majority-white community if they live in a zip code tabulation area where at least 60 percent of the population identifies as members of the respective racial or ethnic group.

The primary outcome we study is medical debt in collections, meaning medical debt sent to a third-party collector or assigned to a creditor's internal collections department (CFPB 2014). Debt in collections is normally at least 180 days past due, and the creditor acted to collect the unpaid debt but was unsuccessful. Our data include for each adult the total amount of unpaid medical debt in collections at the time of each archive. Collections are defined as medical if the original creditor is identified as a medical provider. Medical bills that are paid using a credit card but ultimately go to collections would not appear as medical debt in collections. Two important limitations of our data are that (1) we do not observe flows of new collections, only the stock (collection balance), and (2) a debt appears in collections at the time it is reported to the credit bureau, not at the time the debt is initially incurred.

Notes

[1] A recent Consumer Financial Protection Bureau report highlights a decline in medical debt in collections tradelines and aggregate balances between quarter 1 of 2018 and quarter 2 of 2021 (CFPB 2022).

[2] Starting on July 1, 2022, the three major credit bureau agencies will no longer include paid medical collections on credit reports, and the period before unpaid medical collections appear on a credit report will increase from 6 to 12 months. In the first half of 2023, the agencies will also exclude all unpaid medical collections tradelines under a yet-to-be-determined threshold of at least $500.

[3] If a person pays their medical bill using their credit card but does not pay their credit card bill, this would appear in the credit data as credit card debt, not medical debt.

[4] These studies are based on an analysis of data from the Survey of Income and Program Participation and compare the prevalence of medical debt among households by the race and ethnicity of the householder.

[5] We define "communities of color" as zip codes where at least 60 percent of residents are nonwhite or Hispanic/Latinx and "majority-white communities" as zip codes where at least 60 percent of residents are white and not Hispanic/Latinx. See Breno Braga, Alexander Carther, Kassandra Martinchek, Signe-Mary McKernan, and Caleb Quakenbush, "Debt in America: An Interactive Map," Urban Institute, https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=pct_debt_collections.

[6] Braga, Carther, Martinchek, McKernan, and Quakenbush, "Debt in America."

[7] Sarah Kliff, "With Medical Bills Skyrocketing, More Hospitals Are Suing for Payment," *New York Times*, November 8, 2019, https://www.nytimes.com/2019/11/08/us/hospitals-lawsuits-medical-debt.html; and Michelle McGee

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10 Black and white adults are not Hispanic/Latinx. Adults of "additional races" are non-Hispanic/Latinx adults who are Asian, Native Hawaiian or Pacific Islander, American Indian/Alaska Native, or more than one race. Survey sample sizes do not allow for reporting disaggregated results for the "additional races" category. Interpreting the results for this diverse group of people is difficult, but we include them for completeness.

11 Differences between Black and white adults and between Hispanic/Latinx and white adults in medical debt and problems paying medical bills were statistically significant at the 0.05 level in both 2019 and 2021.

12 We use the 60 percent threshold to be consistent with our past work (Martinchek, Carther, Braga, Quakenbush, and McKernan, "Credit Health during the Pandemic"). We do not provide statistics on Asian Americans, Pacific Islanders, and other racial and ethnic communities because only a small number of zip codes in the US have shares of residents who identify as members of these racial and ethnic groups of at least 60 percent.

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About the Authors

Michael Karpman is a senior research associate in the Health Policy Center at the Urban Institute. His work focuses on the implications of the Affordable Care Act, including quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. His work includes overseeing and analyzing data from the Urban Institute's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Kassandra Martinchek is a research associate in the Center on Labor, Human Services, and Population at the Urban Institute. Their work focuses on understanding disparities in families' food security and financial well-being and policies that can reduce these gaps. Before joining Urban, Martinchek worked in the nonprofit sector implementing and assessing child nutrition programs and in evidence-based state policy research. Martinchek holds a MPA from the University of Wisconsin–Madison and is pursuing her PhD in public policy and administration from George Washington University.

Breno Braga is a labor economist and principal research associate in the Center on Labor, Human Services, and Population at the Urban Institute. His research has covered topics such as the effects of high-skilled immigration on labor markets, the role of local conditions in asset accumulation, and the local factors associated with debt in collections. His articles have been published in academic journals including the *Journal of Labor Economics*. Braga received his MA in economics from the Pontifical Catholic University of Rio de Janeiro and his PhD in economics from the University of Michigan.

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500 L'Enfant Plaza SW
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