Nearly Half of Working-Age Adults Had Difficulties Affording Health Care in 2025

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US households face growing challenges in affording health care as costs have outpaced earnings growth (Claxton et al. 2025; Hartman et al. 2026; Kanimian and Ho 2025).[1] Millions of Americans forgo health insurance coverage and risk catastrophic out-of-pocket expenses because they do not qualify for publicly subsidized coverage, cannot afford premiums, or see limited value in their available health insurance options (Bunch and Ketema 2025). Even with insurance, many struggle to pay for care because of high deductibles, coinsurance, and copayments, or because their plans do not cover certain benefits or providers. Faced with high costs, some people jeopardize their health by delaying or skipping needed care and medications, while others incur medical debt that can undermine their financial security (Karpman et al. 2024, 2025).[2] The expiration of enhanced Marketplace premium tax credits (PTCs) in January 2026 and forthcoming changes to Medicaid and the Marketplaces are expected to increase the number of uninsured and raise cost burdens for families (Buettgens et al. 2025a,b; 2026).[3]

In this brief, we examine difficulties affording health care among families of working-age adults (i.e., those ages 18 to 64) using December 2025 data from the Urban Institute's Well-Being and Basic Needs Survey (WBNS), a nationally representative survey of more than 10,000 adults. We focus on working-age adults because they are more likely to be uninsured and face affordability challenges under the nation's patchwork health insurance system than older adults, who have nearly universal coverage through Medicare. Our definition of the family unit includes the respondent, their spouse or partner, and any of their children younger than age 19 who are living with them.[4]

We estimate the share of adults whose families experienced one or more of the following affordability challenges: (1) someone in the family did not get health care they needed because of its cost in the past 12 months; (2) the family had problems paying or was unable to pay medical bills in the past 12 months; and (3) the family owed medical debt at the time of the survey (see the data and methods section for details on each measure). We find that difficulties affording care were widespread, particularly affecting adults with fair or poor health, chronic health conditions, or disabilities; those who were uninsured; those who are Black, Hispanic, or another race that was not white or Asian; and those living in the South and in rural areas. We also assess whether rising health care costs may be contributing to difficulties affording care by examining the share of adults with private insurance who reported large increases in their families' health insurance premiums and out-of-pocket health care costs in the past year.

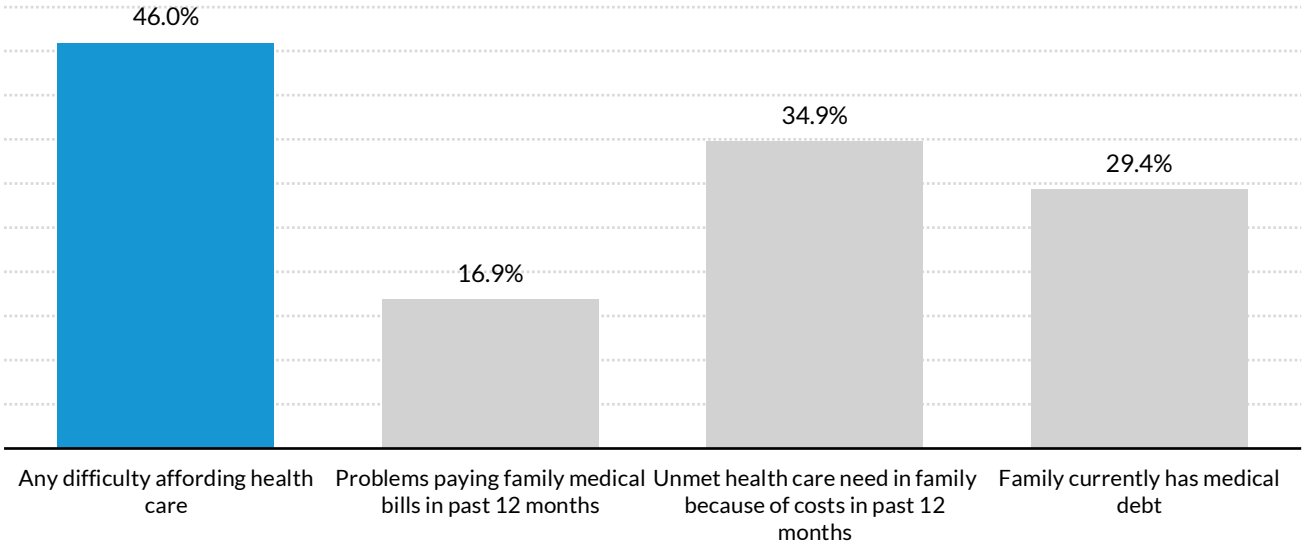
Findings

Nearly Half of Working-Age Adults Faced Difficulty Affording Health Care for Their Families in 2025

In December 2025, 46.0 percent of working-age adults reported their families faced difficulties affording health care (figure 1). This included 16.9 percent of adults ages 18 to 64 reporting problems paying family medical bills in the past year, 34.9 percent reporting someone in the family experienced unmet health care needs because of costs in the past year, and 29.4 percent reporting the family had medical debt at the time of the survey.[5] Many families faced more than one of these difficulties. For instance, 18.9 percent reported both having unmet care needs and owing medical debt (data not shown).

FIGURE 1

Share of Adults Ages 18 to 64 Reporting Difficulty Affording Health Care for Their Families, December 2025



Source: Well-Being and Basic Needs Survey, December 2025.

Uninsured Adults Were More Likely to Be in Families with Unmet Health Needs, but Those with Insurance Coverage Also Experienced Affordability Challenges

Figure 2 shows family health care affordability challenges among working-age adults according to the type of health insurance they had at the time of the survey, both overall and separately for those with family incomes below 200 percent of the federal poverty level (FPL). Overall, uninsured adults were most likely to report at least one affordability problem (60.4 percent). However, families of adults in all three insurance coverage groups also faced difficulty affording care, including 39.0 percent of adults with employer coverage, 53.8 percent with Marketplace or other individual market coverage, and 57.0 percent with Medicaid.[6]

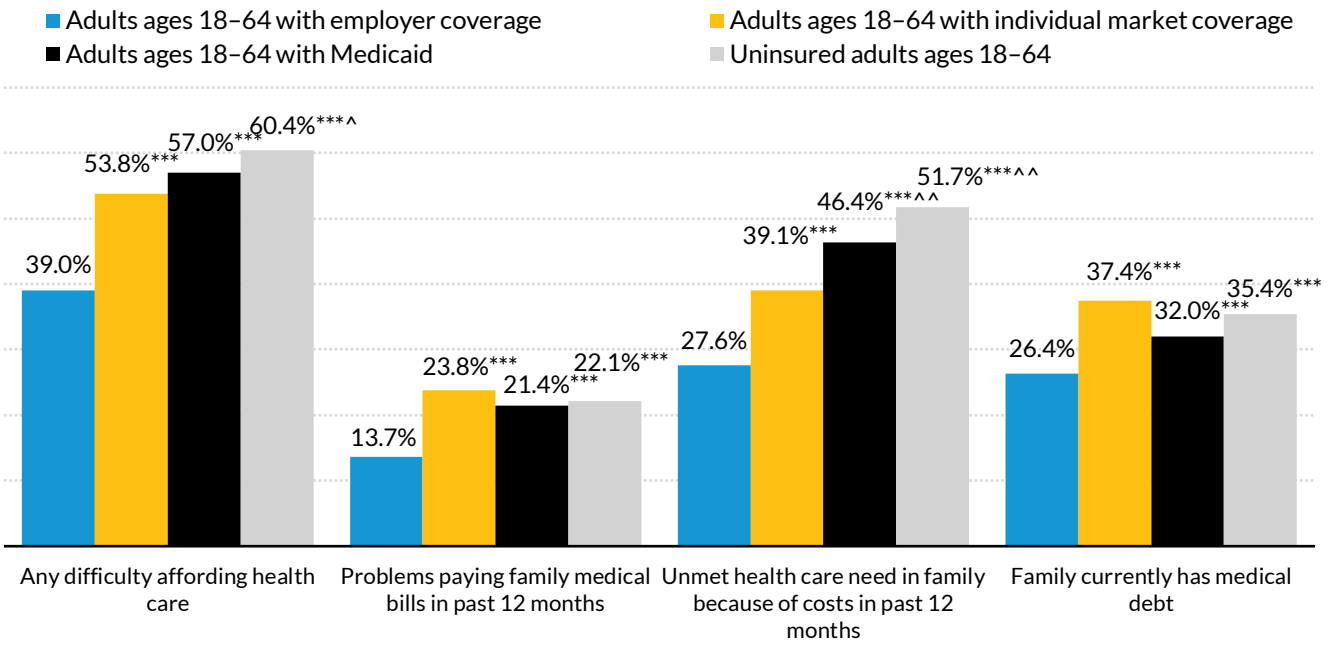
Adults with individual market coverage and those with Medicaid were much more likely than those with employer coverage to face affordability problems overall. However, when we limit these comparisons to low-income families (bottom panel of figure 2), affordability challenges rise significantly for adults with employer or individual market coverage: 63.0 percent of low-income adults with individual market coverage and 54.3 percent with employer coverage faced these challenges, compared with 57.1 percent of low-income adults with Medicaid. Among the insured, differences by type of coverage among lower-income families were not statistically significant, indicating that over half of low-income insured adults were in families that experienced financial difficulties affording health care, and that the lower incomes of those with Medicaid contribute to their families' higher overall rates of difficulty affording care.

Uninsured adults were far more likely than those with employer or individual market coverage to report unmet health care needs because of cost overall (51.7 percent versus 27.6 and 39.1 percent, respectively). Among families with low incomes, the uninsured were more likely to report unmet care needs than those with employer coverage or Medicaid (54.4 percent versus 46.7 and 47.4 percent, respectively). Low-income adults with Medicaid reported lower rates of medical debt (31.9 percent) than those with individual market coverage (45.7 percent) and the uninsured (38.2 percent).

FIGURE 2

Share of Adults Ages 18 to 64 Reporting Difficulty Affording Health Care for Their Families, by Type of Health Insurance Coverage and Family Income, December 2025

All incomes:



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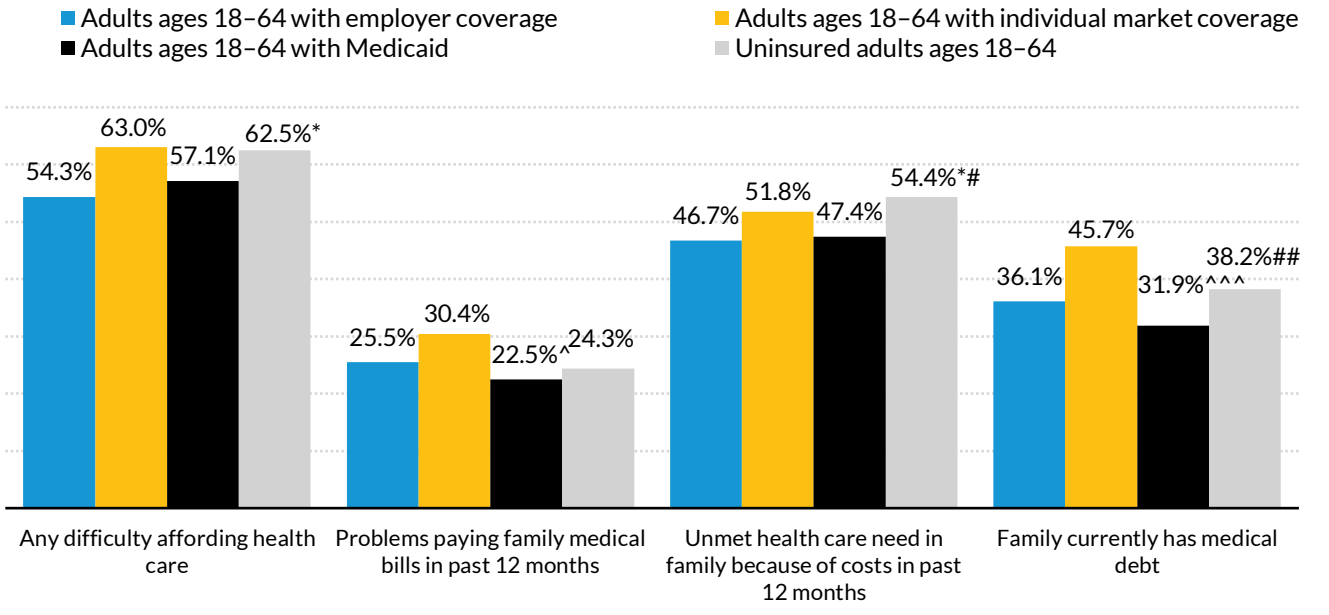
Among adults with family income <200 percent of FPL:



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Source: Well-Being and Basic Needs Survey, December 2025.

Notes: FPL = federal poverty level. Other insurance coverage types not shown.

*/**/*** Estimate differs significantly from estimate for adults with employer coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from estimate for adults with individual market coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

#/##/### Estimate differs significantly from estimate for adults with Medicaid at the 0.10/0.05/0.01 level, using two-tailed tests.

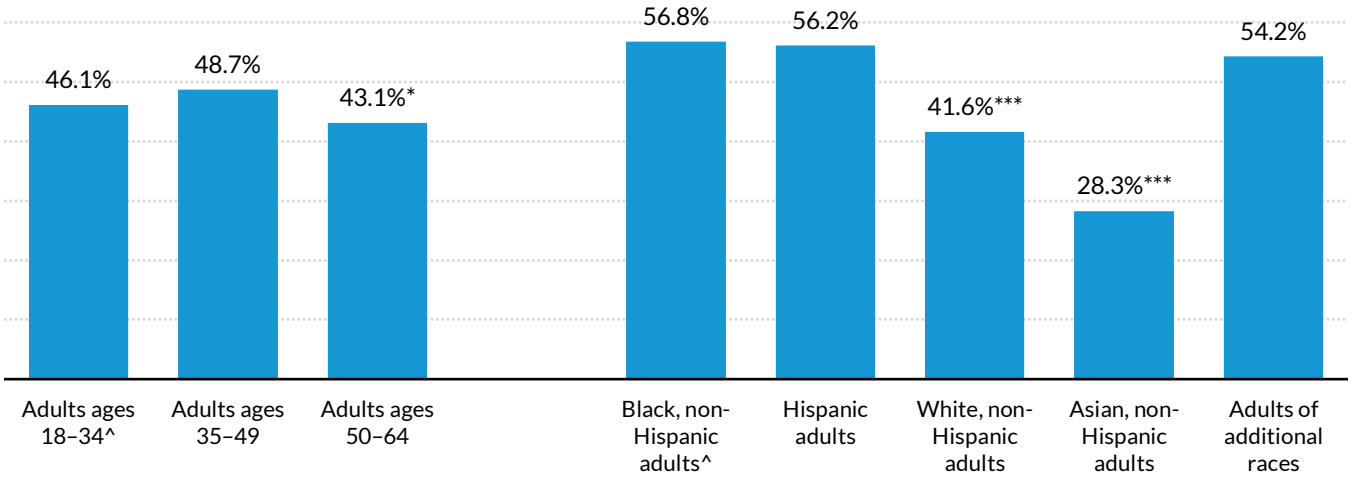
Although these estimates are based on the respondent's coverage type at the time of the survey, and affordability challenges may have been experienced by another family member with different coverage or while the respondent had different coverage, they are consistent with other studies (Bernard, Selden, and Fang 2023; Collins, Roy, and Masitha 2023; Coughlin et al. 2013; Karpman et al. 2024) and indicate that insurance coverage is not always sufficient to protect families from health care affordability difficulties. Affordability problems among those with insurance may stem from cost-sharing requirements or other factors, including benefits and medications that health plans limit or do not cover, out-of-network providers, or denied claims. For instance, though Medicaid enrollees face little to no cost-sharing, even small copayments can pose a barrier to getting care (Artiga, Ubri, and Zur 2017; Hartung et al. 2008; Kostova and Fox 2017; Subramanian 2011). Medicaid enrollees also have greater health needs on average than privately-insured adults, may lack access to certain benefits, such as dental care, that are optional for states to cover, and may face disruptions in coverage because of changing eligibility or difficulty navigating renewal processes (Clemans-Cope, Holahan, and Garfield 2016; Hinton and Paradise 2016; Karpman, Long, and Bart 2018; Sugar et al. 2021).

Affordability Challenges Were More Common Among Families of Adults Who Are Black or Hispanic, but Did Not Vary Much by the Adult's Age

More than half of non-Hispanic Black adults (56.8 percent), Hispanic adults (56.2 percent), and other non-Hispanic adults who were not white or Asian (a group that includes American Indians/Alaska Natives, Native Hawaiians/Pacific Islanders, and those reporting another race or more than one race; 54.2 percent) reported that their family had difficulties affording health care (figure 3). This was higher than for those who identified as non-Hispanic white (41.6 percent) or Asian (28.3 percent).[7] Differences by age were smaller, with 43 to 49 percent of all age groups reporting that their family experienced challenges affording health care.

FIGURE 3

Share of Adults Ages 18 to 64 Reporting Difficulty Affording Health Care for Their Families, by Age and Race/Ethnicity, December 2025



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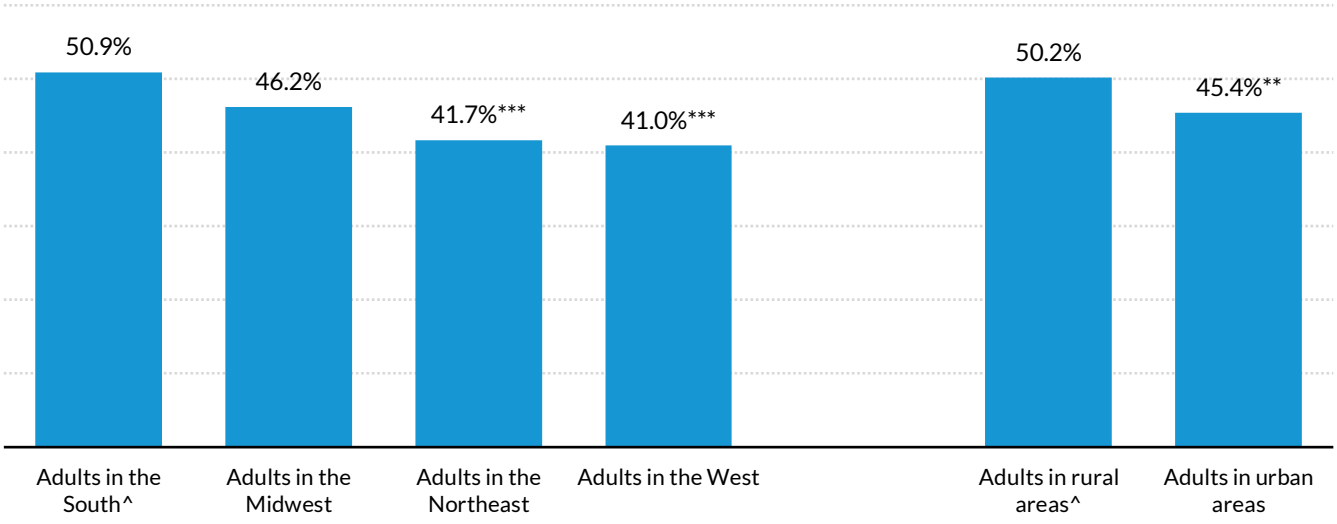
Source: Well-Being and Basic Needs Survey, December 2025.
Notes: Health care affordability difficulties refer to the respondent reporting problems paying family medical bills in the past year, someone in the family experiencing unmet health care needs because of costs in the past year, and/or that their family had medical debt at the time of the survey. Age and race/ethnicity refer to self-reported characteristics of the respondent. Adults of additional races include non-Hispanic adults who are American Indian or Alaska Native, Native Hawaiian or Pacific Islander, another race, or of more than one race.
*/**/*** Estimate differs significantly from reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

Half of Adults Living in the South and in Rural Areas Reported Affordability Difficulties

Reported difficulties affording health care were more common in certain regions and communities, affecting just over half of families in the southern census region (50.9 percent) and in rural areas (50.2 percent; figure 4). People living in the South may experience greater affordability challenges because of the region's higher uninsured rates, which are in part related to the lack of Medicaid expansion in many southern states (Carter 2025).[8] But affordability challenges were widespread across the country, with more than 4 in 10 adults in every region and outside of rural areas reporting difficulties affording health care.

FIGURE 4

Share of Adults Ages 18 to 64 Reporting Difficulty Affording Health Care for Their Families, by Region and Rurality, December 2025



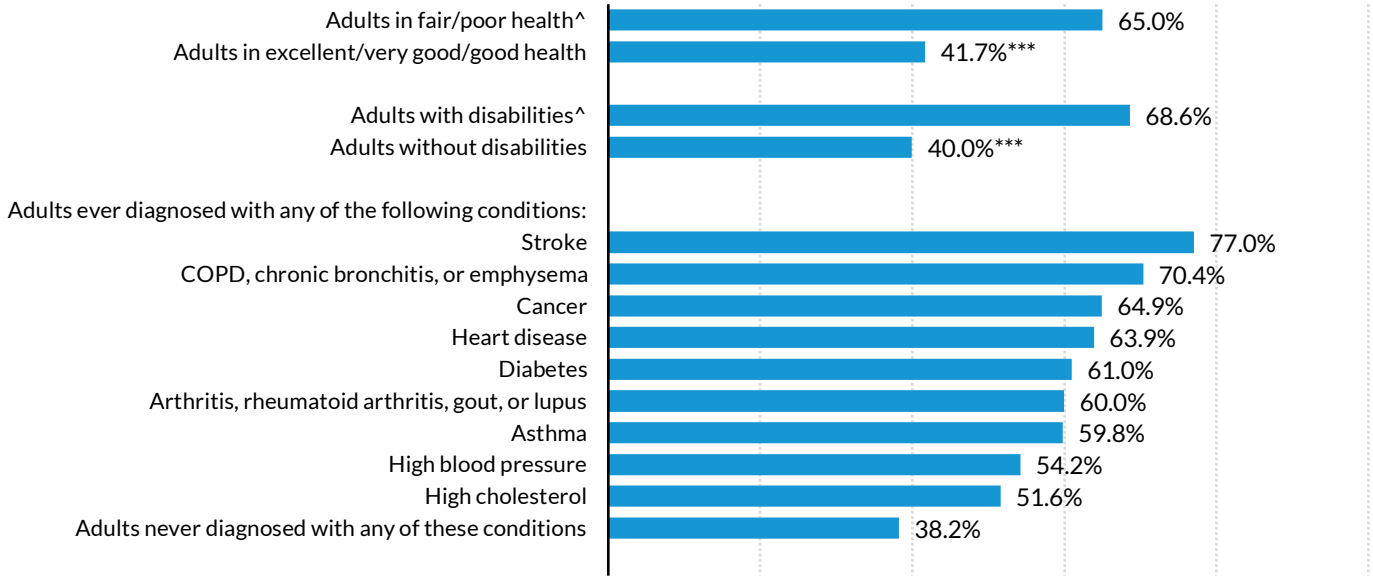
Source: Well-Being and Basic Needs Survey, December 2025.
Notes: Health care affordability difficulties refer to the respondent reporting problems paying family medical bills in the past year, someone in the family experiencing unmet health care needs because of costs in the past year, and/or that their family had medical debt at the time of the survey. Respondents who live in a metropolitan statistical area are categorized as living in urban areas; those living outside of metropolitan statistical areas are categorized as living in rural areas.
*/**/*** Estimate differs significantly from reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

More than 6 in 10 Adults Who Are in Fair or Poor Health or Have a Disability Faced Difficulty Affording Care

Approximately two-thirds of working-age adults in fair or poor health (65 percent) or with a disability (68.6 percent) reported one or more affordability problems (figure 5). In addition, more than half of those who had ever been diagnosed with one or more of nine chronic conditions reported affordability difficulties, including more than 70 percent of adults with stroke or chronic obstructive pulmonary disease and more than 60 percent of those ever diagnosed with cancer, heart disease, or diabetes. Difficulties affording care were less common among adults without any of these conditions, who may have had fewer encounters with the health care system and consequently less exposure to high costs (38.2 percent), though some of these adults may have had other chronic conditions that the survey did not ask about.

FIGURE 5

Share of Adults Ages 18 to 64 Reporting Difficulty Affording Health Care for Their Families, by Health Status, Disability Status, and Diagnosed Health Conditions, December 2025



Source: Well-Being and Basic Needs Survey, December 2025.

Notes: COPD = chronic obstructive pulmonary disease. Health care affordability difficulties refer to the respondent reporting problems paying family medical bills in the past year, someone in the family experiencing unmet health care needs because of costs in the past year, and/or that their family had medical debt at the time of the survey. Health status, disability status, and chronic condition diagnosis refer to self-reported characteristics of the respondent.

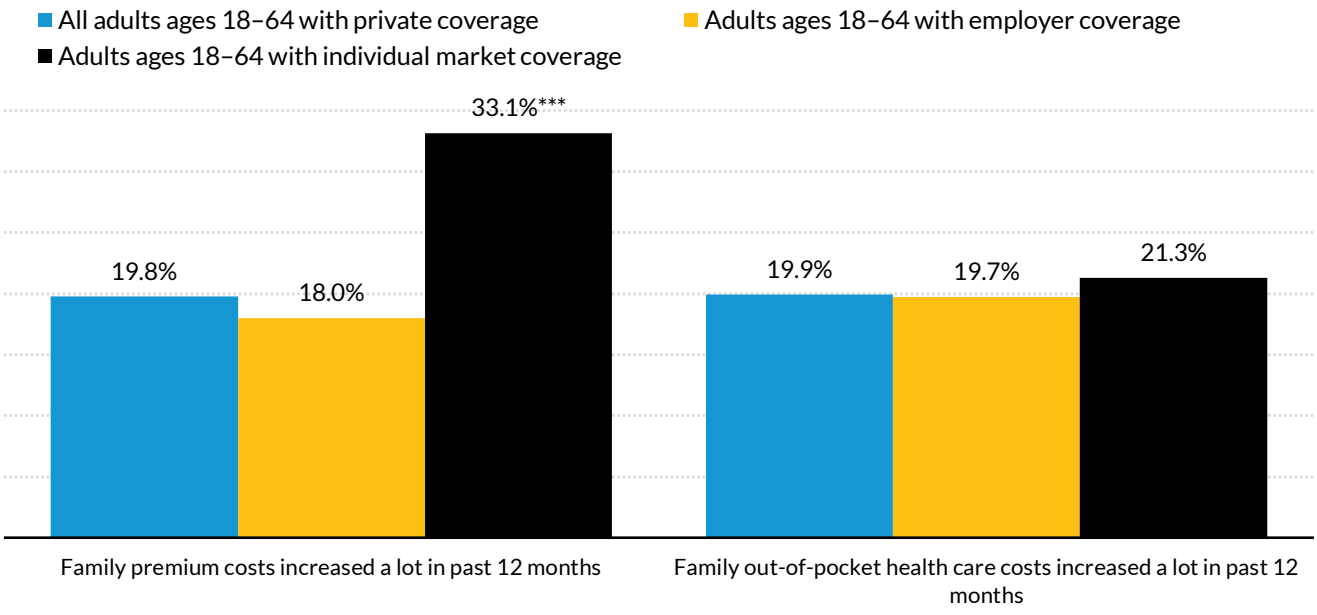
*/**/*** Estimate differs significantly from estimate for reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests. All estimates for adults with selected chronic conditions differ significantly from the estimate for adults never diagnosed with these conditions at the 0.01 level.

About 1 in 3 Adults with Individual Market Coverage Reported Facing Steep Increases in Health Insurance Premiums in the Prior Year

Increasing costs for health insurance coverage and health care may have contributed to families' affordability challenges. Figure 6 shows the share of adults with employer or individual market coverage who reported that the costs their families pay for health insurance premiums or their out-of-pocket medical costs (excluding premiums) increased a lot in the 12 months before the December 2025 survey. Overall, about 1 in 5 adults with private health insurance coverage (19.8 percent) reported large premium increases. Adults with individual market coverage were nearly twice as likely as those with employer coverage to report large premium increases (33.1 percent versus 18.0 percent).[9] About 1 in 5 adults (19.9 percent) with private insurance also reported their family out-of-pocket health care costs (excluding premiums) increased a lot in the past 12 months, a rate that was similar among those with employer coverage (19.7 percent) and individual market coverage (21.3 percent).[10]

FIGURE 6

Share of Adults Ages 18 to 64 Reporting Health Care Costs Increased a Lot for Their Families in the Past 12 Months, by Type of Health Insurance Coverage, December 2025



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Source: Well-Being and Basic Needs Survey, December 2025.
Notes: Increases in costs refer to costs for the family. Health insurance coverage refers to coverage of the respondent.
*/**/*** Estimate differs significantly from estimate for adults with employer coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Analysis of a large, nationally representative sample finds that nearly half of working-age adults had difficulties affording health care for their families in 2025 and that these burdens fell unevenly across people and places. Although the uninsured were more likely than insured respondents to report affordability challenges overall and to forgo needed care because of its cost, many families with employer coverage, individual market coverage, or Medicaid also reported struggling to afford health care.

Adults in fair or poor health, with disabilities, or diagnosed with selected chronic conditions were much more likely than other adults to report that their families faced affordability challenges. About two-thirds of adults in fair or poor health, and a similar share of those with disabilities, faced difficulties affording health care for themselves or their families. For adults with certain chronic conditions such as cancer, heart disease, stroke, or diabetes, the share with problems affording care exceeded 60 percent. Financial barriers to accessing care and the stress associated with being unable to pay medical bills could hinder their ability to manage their conditions, increase their risk of hospitalization, and prevent them from getting lifesaving treatment (Borgschulte and Vogler 2020; Gilligan et al. 2018; Wen et al. 2019).

Recent increases in health insurance premiums and out-of-pocket health care costs may be exacerbating affordability challenges for those with private insurance coverage. One in three respondents with individual market coverage and about one in five with private health insurance coverage overall reported that their premiums increased a lot in the year prior to the December 2025 survey. The findings for those with individual market coverage may be capturing early experiences related to increasing Marketplace premiums and the expiration of the enhanced PTCs, to the extent that respondents may have been in the process of shopping for or renewing their

coverage during the Marketplace open enrollment period, which occurred between November 1, 2025, and January 15, 2026, in most states. The average monthly premium for a single 40-year-old adult buying an unsubsidized benchmark plan through the Marketplaces in 2026 increased by 22 percent from the prior year, from $500 to $609, with deductibles for these plans typically exceeding $5,000 (Holahan, O'Brien, and Kennedy 2025; Holahan, Simpson, and Wengle 2025). The loss of enhanced subsidies at the end of 2025 further exposed millions of Marketplace enrollees to higher premium costs (Buettgens et al. 2025b). However, one in five adults with employer coverage also reported large increases in premiums, indicating this issue is not limited to the Affordable Care Act (ACA) Marketplaces. As employers shift some of the rise in health care costs to employees in 2026 through increased deductibles and coinsurance, difficulties affording health care may increase.[11]

Americans face challenges affording the health care they need for several reasons. A fundamental issue is the lack of a guarantee of affordable coverage and care for every American. Although uninsurance rates have fallen dramatically since the passage of the ACA, a large number of individuals remain uninsured and are more likely to face barriers to care and experience high rates of unmet health care needs.

But as the data in this brief show, insurance often does not provide sufficient financial protection from the costs of obtaining health care. Health insurance premiums, deductibles, and other forms of cost-sharing strain families' resources and can often lead to forgone care and medical debt. The proximate drivers of high health care costs in the US include elevated prices, an aging population, and high levels of chronic disease (Anderson, Hussey, and Petrosyan 2019; Chang, Mirvis, and Mahmood 2026).[12] Lowering health care prices would require tackling hospital and insurer consolidation, sometimes excessive provider payment rates, prescription drug costs (both existing and new-to-market), workforce shortages, and other structural factors. Federal and state action through antitrust enforcement; enhanced regulation of provider and insurer pricing; efforts to address ownership and contracting arrangements among health care providers, insurers, and administrative and financial middlemen entities that increase administrative costs and generate financial conflicts of interest; and pharmacy benefit manager oversight are among the set of policies that could help slow the rise in health care costs (Blumberg, Lucia, and Watts 2025; CBO 2022).[13]

Recent federal policy changes are expected to exacerbate difficulties affording health insurance coverage and health care in the years ahead by increasing the number of uninsured.[14] It is anticipated that the One Big Beautiful Bill Act (OBBBA) will reduce Medicaid enrollment by instituting six-month eligibility redetermination and work requirement provisions for Medicaid expansion coverage. Urban Institute analysis projects that these OBBBA provisions will result in between 4.9 and 10.1 million fewer adults enrolled in Medicaid in 2028, depending on how states implement them (Buettgens et al. 2026). In addition, the expiration of the pandemic-era enhanced PTCs for Marketplace coverage is projected to result in 7.3 million fewer subsidized Marketplace enrollees in 2026 and 4.8 million more uninsured individuals (Buettgens et al. 2025b). OBBBA restrictions on PTC eligibility for lawfully present immigrants, its bar on automatic enrollment, and its elimination of provisional eligibility for PTCs will push Marketplace enrollment down by potentially several million more (Buettgens et al. 2025a).[15] Those losing Medicaid or Marketplace coverage who become uninsured are expected to face much larger affordability problems, but even those who can obtain employer-sponsored insurance could face financial hardships and barriers to care, depending on the premiums, cost sharing, and benefits of those plans. Future rounds of the WBNS will monitor how affordability changes under the implementation of these policies.

States can attenuate some of the coverage losses that will result from the six-month redetermination and work requirement provisions of OBBBA by taking steps such as increasing ex parte Medicaid renewals and broadening data sources for assessing compliance and exemptions from work requirements (Buettgens et al. 2026), but significant coverage losses—and increased affordability hardships—remain likely. Looking ahead, policies that strengthen and build on the ACA by making Marketplace coverage more affordable and that lower enrollment and

retention barriers for those eligible for Medicaid or PTCs could meaningfully improve affordability for people who rely on these programs (Holahan and Simpson 2025).

Reversing recent federal policy actions that are expected to cause coverage loss in Medicaid and the individual market would improve access to care for millions, but the longstanding problem of unaffordable health care in the US requires more systemic reform.

Data and Methods

The WBNS is a nationally representative, annual survey of adults that monitors individual and family well-being in the context of a changing safety net. Launched by the Urban Institute in December 2017, the WBNS provides timely information on the challenges that households face in meeting basic needs such as food, housing, and health care.

More than 10,000 adults ages 18 and older participated in the December 2025 round of the survey, including nearly 8,000 adults ages 18 to 64. For each survey round, we draw a stratified random sample from the KnowledgePanel, a probability-based internet panel that is maintained by Ipsos and includes households with and without internet access. Survey weights adjust for unequal selection probabilities from the panel and are poststratified to the characteristics of adults based on benchmarks from the Current Population Survey and American Community Survey (ACS). Participants can complete the survey in English or Spanish. For further information on the survey design before the 2025 change in sampling, see Karpman, Zuckerman, and Gonzalez (2018).

Key Measures

We examined the share of adults ages 18 to 64 who indicated that their families have had difficulty affording health care. Our definition of difficulty affording care includes instances in which respondents reported one or more of the following experiences:

Problems paying family medical bills in the past 12 months. Survey respondents were asked, "In the past 12 months, did you or anyone in your family have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care."

Unmet health care needs in the family because of costs in the past 12 months. Respondents were asked whether there was a time in the past 12 months when they or someone else in their family "needed any of the following types of health care but **did not** get it because you/your family couldn't afford it": prescription drugs; to see a doctor; medical tests, treatment, or follow-up care; dental care; mental health care or counseling; or treatment or counseling for alcohol or drug use. Respondents were first asked about unmet care needs for themselves and then asked about unmet care needs for other family members.

The family owed medical debt at the time of the survey: This question focused on whether respondents or their families currently owe any money for medical or dental bills they were unable to pay in full. These bills may have been from the past year or earlier years. Respondents were asked if they or their families currently have:

- any medical or dental bills that are past due or that they are unable to pay
- any medical or dental bills they are paying off over time directly to a health care or dental care provider
- any medical or dental bills they put on a credit card and are paying off over time
- any debt they owe to a bank, collection agency, or other lender that includes debt or loans used to pay medical or dental bills
- any debt they owe to a family member or friend for money borrowed to pay medical or dental bills

For each of these questions, the family unit was defined as the respondent, their spouse or partner if applicable, and any of their own children younger than 19 years of age who are living with them. For single, 18-year-old respondents without children, their family included themselves, their parents who are living with them, and any of their siblings younger than age 19 who are living with them. These family unit definitions are narrower than the Census Bureau definition, which includes all individuals in a household who are related by birth, adoption, or marriage.

The questions on problems paying family medical bills and unmet health care needs were adapted from the National Health Interview Survey (NHIS). The question on medical debt draws on language from both the Survey of Income and Program Participation and KFF's 2022 Health Care Debt Survey (Lopes et al. 2022). However, estimates from the WBNS are not directly comparable to these other surveys because of differences in timing, sampling design, and question wording.

Along with the questions about health care affordability challenges, we asked respondents how the costs they and their families pay for certain expenses changed in the past 12 months, including health insurance premiums and out-of-pocket health care costs (not including premiums). They could report these costs increased a lot, increased a little, stayed about the same, decreased a little, or decreased a lot, or that they "don't know" or the question was not applicable. The order of these response categories was randomized, with half the sample seeing the items ordered from "increased a lot" to "decreased a lot" and the other half seeing the items ordered from "decreased a lot" to "increased a lot." Respondents may have reported "not applicable" for several reasons, including not having had coverage or a premium 12 months prior to the survey, not having a premium because it was fully subsidized, or not having had any out-of-pocket health care costs because they did not visit a health care provider, take medications, or receive other health services. The WBNS questionnaire is available on the Urban Institute's website.[16]

Analysis

We focused on the health care affordability experiences of adults ages 18 to 64 and their families, overall and by the respondent's type of health insurance coverage reported at the time of the survey; age; race/ethnicity; self-reported health status; disability status; selected diagnosed health conditions; census region; and residence in a rural or urban area.

When comparing affordability based on the respondent's coverage type, we focus on adults with employer-sponsored health insurance (including coverage through a current or former employer or union or through the military, such as TRICARE or VA health care), Marketplace or other individual market coverage, Medicaid (including CHIP), and those who were uninsured. Our analysis excludes adults with Medicare or unspecified coverage, who represent 4 percent and 2.9 percent of the sample of working-age adults, respectively. Adults who only reported coverage through the Indian Health Service are categorized as uninsured.

Because respondents could report more than one type of coverage, we assign them to mutually exclusive categories based on the following hierarchy of responses: employer coverage, Medicare, Medicaid, individual market coverage, unspecified coverage, or uninsured. This hierarchy is a modified version of an approach developed by the State Health Access Data Assistance Center, which categorizes people based on their likely primary source of coverage (Hest and Liu 2024).[17] In addition, we compare health care affordability challenges by coverage type, both overall and among adults with family incomes below 200 percent of FPL, since few working-age adults with incomes above that threshold are eligible for Medicaid.

Rural/urban status is defined based on whether respondents live in a metropolitan statistical area. Health status is self-reported, with options to report general health that is excellent, very good, good, fair, or poor. Disability status is based on six questions drawn from the ACS on functional limitations that include difficulties with vision, hearing, mobility, cognition, self-care, and independent living, and a seventh question on communication difficulties.

Diagnosed medical conditions include nine selected conditions that a doctor or other health professional ever told the respondent they had. These conditions are based on similar questions in the NHIS.

Limitations

The WBNS has several limitations, including a low cumulative response rate, and the survey weights mitigate but do not eliminate potential nonresponse bias. However, studies assessing recruitment for the KnowledgePanel have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008), and WBNS estimates are generally consistent with benchmarks from federal surveys (Karpman, Zuckerman, and Gonzalez 2018).

The sampling frame for the WBNS also excludes or underrepresents certain groups of adults, including those experiencing homelessness, those who have low literacy levels, and those who are not proficient in English or Spanish. The exclusion of Asian adults who do not speak English or Spanish may result in an underestimation of affordability challenges among this group, because a higher share of Asian adults have limited English proficiency compared with other racial and ethnic groups, and this varies substantially across subgroups of the Asian population (Haley et al. 2022).

Because affordability challenges are reported for the family and primarily focus on the past 12 months, there is a potential mismatch between the health insurance status of the respondent or their family member at the time the affordability issue was experienced and the respondent's coverage at the time of the survey. For instance, unmet health care needs and problems paying medical bills may have been related to cost-sharing requirements under another family member's health plan or a time when they were uninsured, or the respondent may have switched health plans or had gaps in health insurance during the previous year. The WBNS did not collect information about the respondent's coverage in the past 12 months or the coverage of other family members. Additionally, a respondent's diagnosed health conditions may include conditions that no longer require ongoing care.

Survey estimates are also subject to recall bias and other forms of measurement error. For instance, studies have found errors in survey-reported health insurance coverage type (Pascale 2008). Respondents may not remember the affordability issues they experienced in the past year or may not be aware of other family members' decisions to forgo care because of cost concerns. They may also be unaware of the status of their medical debt and whether providers or collection agencies are still attempting to collect payment. Respondents may have interpreted certain questions differently, such as the question asking about problems paying medical bills. Finally, respondents reported their subjective experiences of how their premiums and out-of-pocket health care costs changed in the past year, and may not always have been aware of how their costs changed.

Notes

[1] Urban Institute, "The American Affordability Tracker," accessed May 5, 2026, https://www.urban.org/data-tools/american-affordability-tracker.

[2] Urban Institute, "Debt in America: An Interactive Map," accessed May 5, 2026, https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll; and Urban Institute, "The Changing Medical Debt Landscape in the United States," accessed May 5, 2026, https://apps.urban.org/features/medical-debt-over-time/.

[3] Edwin Park, "New CBO Health Coverage Estimates of Budget Reconciliation Law," Georgetown University Center for Children and Families (blog), August 14, 2025, https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/.

[4] For single 18-year-old respondents without children, the family unit includes the respondent, their parents who are living with them, and their siblings younger than age 19 who are living with them.

[5] The WBNS defines affordability problems to include dental care, which may not be covered by health insurance. When defining difficulties affording health care to exclude dental care, the share with unmet health care needs because of costs in the past year would be 28.9 percent, the share with medical debt would be 26.0 percent, and the share with any difficulty affording health care would be 41.1 percent. Questions about problems paying medical bills do not disaggregate dental bills from other types of medical bills.

[6] The survey asked whether respondents were covered by Medicaid or the Children's Health Insurance Program (CHIP). A small number of 18-year-olds or pregnant/postpartum individuals may be covered by CHIP, and we group them together with those covered by Medicaid in figure 2.

[7] Because the panel from which WBNS respondents are sampled excludes those who are not proficient in English or Spanish, our sample does not include Asian adults who only speak other languages, which may result in an underestimation of health care affordability problems among this group. Significantly more Asian adults have limited English proficiency compared with Black or white adults, and this varies substantially across subgroups of the Asian population (Haley et al. 2022). However, our finding of lower affordability problems among Asian adults is similar to estimates from the National Health Interview Survey (authors' tabulations), which uses more interview languages.

[8] KFF, "Status of State Medicaid Expansion Decisions," May 6, 2026, https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/.

[9] These patterns were consistent among adults who were not married or living with a partner, with 14.7 percent of those with employer coverage and 30 percent of those with individual market coverage reporting their health insurance premiums increased a lot in the past year, indicating that the differences in cost increases found in figure 6 are unrelated to premium changes for a different type of coverage held by a family member other than the respondent.

[10] Most of the remaining adults with private coverage reported their premiums and out-of-pocket health care costs increased a little or stayed the same. About 1 to 2 percent reported a decrease in these costs. The remaining 18 to 21 percent reported they did not know or the question did not apply to them. People may have selected "not applicable" for many reasons, including not paying a premium if it was fully subsidized, not having had coverage 12 months before the survey, or not having any out-of-pocket health care costs if they did not visit a health care provider.

When asked how their family's premium and out-of-pocket costs changed in the past year, most adults who were uninsured or had Medicaid coverage reported the question was not applicable or they did not know, likely because most Medicaid enrollees do not have premiums and face limited cost sharing, and because uninsured adults use less care than their peers (Zhou et al. 2017). Medicaid enrollees were less likely than those with employer or individual market coverage to report their out-of-pocket costs increased a lot (10.1 percent); 18.1 percent of uninsured adults reported out-of-pocket costs increased a lot, a similar rate as those with private coverage (data not shown).

[11] Beth Umland, "As Benefit Costs Surge, Employers Face Tough Decisions for 2026," Mercer, July 17, 2025, https://www.mercer.com/en-us/insights/us-health-news/as-benefit-costs-surge-employers-face-tough-decisions-for-2026/.

[12] Peter G. Peterson Foundation, "Why Are Americans Paying More for Healthcare?," accessed May 13, 2026, https://www.pgpf.org/article/why-are-americans-paying-more-for-healthcare/; Imani Telesford, Matthew McGough, Delaney Tevis, and Lynn Cotter, "How Has the Burden of Chronic Diseases in the U.S. and Peer Nations Changed over Time?" Peterson-KFF Health System Tracker, April 16, 2025, https://www.healthsystemtracker.org/chart-collection/how-has-the-burden-of-chronic-diseases-in-the-u-s-and-peer-nations-changed-over-time/; and Cynthia Cox, Jared Ortaliza, Emma Wager, and Krutika Amin, "Health Care Costs and Affordability," October 8, 2025, https://www.kff.org/health-costs/health-policy-101-health-care-costs-and-affordability/.

[13] Urban Institute, "Policy Solutions for an Affordable Future: Health Care Affordability," April 2, 2026, https://www.urban.org/apps/policy-solutions-affordable-future/health-care.

[14] Jared Ortaliza, Matt McGough, Cynthia Cox, Kaye Pestaina, Robin Rudowitz, and Alice Burns, "How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?" KFF, June 18, 2025, https://www.kff.org/affordable-care-act/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/.

[15] Philip L. Swagel, "Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act," Letter to Ranking Member Wyden, Ranking Member Pallone, and Ranking Member Neal, CBO, June 4, 2025.

[16] Urban Institute, "The Well-Being and Basic Needs Survey," accessed May 5, 2026, https://www.urban.org/policy-centers/health-policy-center/projects/well-being-and-basic-needs-survey.

[17] One deviation from this approach for working-age adults is that we place employer/military coverage above Medicare, since the primary source of coverage for working-age adults with both types of coverage varies based on the type of group coverage and the number of employees at the firm through which it is offered. See Medicare Rights Center, "When Medicare is Primary or Secondary," accessed May 5, 2026, https://www.medicareinteractive.org/understanding-medicare/coordinating-medicare-with-other-insurance/coordination-of-benefits-basics/when-medicare-is-primary-and-secondary.

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