



MEDICAL DEBT IN NEW JERSEY

A DEEP DIVE INTO THE PROBLEM AND POLICY SOLUTIONS



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INTRODUCTION: THE INCREASING PROBLEM OF MEDICAL DEBT IN THE U.S.

Medical debt is a serious problem for American consumers—the Census Bureau estimates that in 2017, 19 percent of U.S. households carried medical debt, while a *JAMA* study estimated that 17.8 percent of individuals in the U.S. had medical debt in collections in June 2020.^{1,2} In New Jersey alone, an estimated 1.1 million people have unpaid medical bills, roughly 16.2 percent of the adult population.³ While COVID-19 had a somewhat limiting effect on medical debt, researchers do not expect this to continue (for more information, see Appendix B).

Medical debt has risen to prominence as an issue in recent years and has been directly addressed in recent private-sector and federal policies. The three major nationwide credit reporting agencies announced in March 2022 that they will no longer include paid medical collection debt on consumer credit reports and will not include unpaid medical debt on a consumer’s report until one year, up from 6 months previously.⁴ The Biden-Harris Administration also addressed medical debt in April 2022—among other policies, the Administration provided guidance to all agencies on eliminating medical debt as a factor for underwriting in credit programs whenever possible.⁵ Finally, the No Surprises Act, which took effect in January 2022, disrupts the medical debt collection cycle by minimizing surprise medical bills, protecting consumers from balance billing and removing consumers from insurance-provider price negotiations.⁶

Medical debt does not affect all consumers equally—people of color are disproportionately impacted by this issue.⁷ According to the Census Bureau, almost 28 percent of Black and almost 22 percent of Hispanic households report having medical debt, compared to 17.2 percent of non-Hispanic white households and 9.7 percent of Asian households.^{8,9} Similar disparities have been documented in New Jersey—the Urban Institute estimates that 11 percent of state residents have medical debt *in collections*, but the estimate increases to 17 percent when looking exclusively at New Jersey communities of color.¹⁰ By comparison, roughly 8 percent of majority-white New Jersey communities report having medical debt in collections.

The No Surprises Act

The No Surprises Act protects consumers from accruing medical debt by making care more affordable. The Act outlaws providers from billing patients more than the in-network cost-sharing due under their insurance plans for all out-of-network emergency facility and professional services, as well as some other care scenarios. When the consumer’s cost-sharing obligation is in coinsurance, their cost must be based on the “qualifying payment amount”—generally the insurer’s historical median in-network rate for the service. The Act directly addresses healthcare affordability, ensuring that consumers aren’t charged exorbitant amounts for needed care and reducing the likelihood of medical debt stemming from unpaid bills. By removing consumers from the arbitration process, the Act could save consumers time and reduces the likelihood of their accruing legal fees fighting unjust bills. However, time will tell the true impact of these new protections on consumers’ medical debt levels.

Nationwide, uninsured individuals and those living in low-income households are also more likely to experience medical debt. The Census Bureau estimates that 30 percent of households that were not fully insured in 2017 had medical debt, compared to 16.2 percent of households with health insurance coverage for all members throughout the year.¹¹ The Bureau also found that 11.3 percent of impoverished households reported a high medical debt burden (i.e. debt exceeding 20% of the household annual income), compared to just 3 percent of households with incomes above the poverty threshold. Furthermore, Black and Hispanic households experience a much higher poverty rate than white households.¹²

The racial and economic distribution of medical debt poses a serious threat to health equity. The populations that experience the largest burdens of medical debt are the same populations that already experience disproportionate levels of chronic disease, are more likely to lack a usual healthcare provider and are more likely to go without needed care.¹³ Additional financial strain on communities of color and lower-income communities caused by medical debt increases the likelihood that people will delay or avoid needed care in the future.¹⁴ The Healthcare Value Hub's 2022 survey on medical debt in New Jersey found that more than one third of New Jersey respondents with medical debt (36%) reported that their medical debt prevented them or a family member who lives with them from seeking needed care.¹⁵ Hispanic/Latinx respondents were the most likely to report that their medical debt caused them to avoid needed care (49%), compared to Black/African American respondents (40%) and white respondents (36%).

This report examines the impact of medical debt on New Jersey residents, the causes of medical debt and policy solutions states have implemented to reduce the incidence of medical debt and prevent harm to residents.

MEDICAL DEBT IN NEW JERSEY—A SNAPSHOT

Though current data on medical debt in New Jersey is limited, a few resources shed light on the subject, including the Healthcare Value Hub's 2022 New Jersey Medical Debt Survey¹⁶ and the Urban Institute's interactive medical debt map.¹⁷ Taken together, the resources reveal the spread, depth and impact of medical debt on New Jerseyans' health and finances.

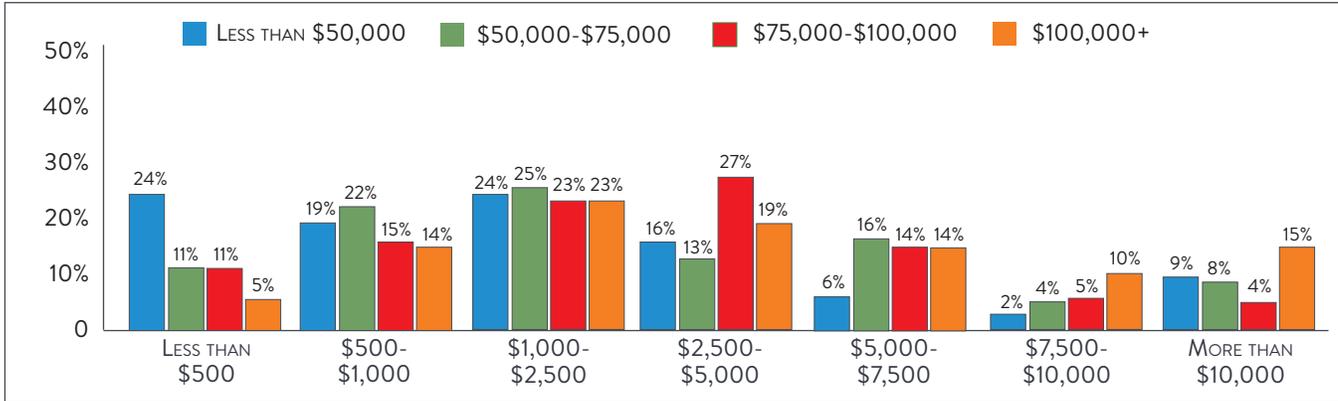
AMOUNT AND INCIDENCE OF MEDICAL DEBT IN NEW JERSEY

The Healthcare Value Hub's medical debt survey found that roughly 6 in 10 (59%) of New Jerseyans with medical debt surveyed owe between \$500 and \$5,000 in medical debt.¹⁸ More than 1 in 6 respondents (17%) report owing \$7,500 or more. Interestingly, people living in lower- and middle-income households more frequently reported incurring lower levels of debt compared to higher-income earners (see Figure 1). Higher-income earners more frequently reported incurring debt above \$7,500.

Differences in amounts of medical debt were also seen across racial/ethnic groups.¹⁹ Hispanic/Latinx respondents most commonly reported owing less than \$2,500 in medical debt (63%), followed by Black/African American respondents (53%) and white respondents (52%). White respondents most commonly reported having \$7,500 or more in medical debt (17%), compared to Hispanic/Latinx (9%) and Black/African American (11%) respondents (see Figure 2).

Figure 1

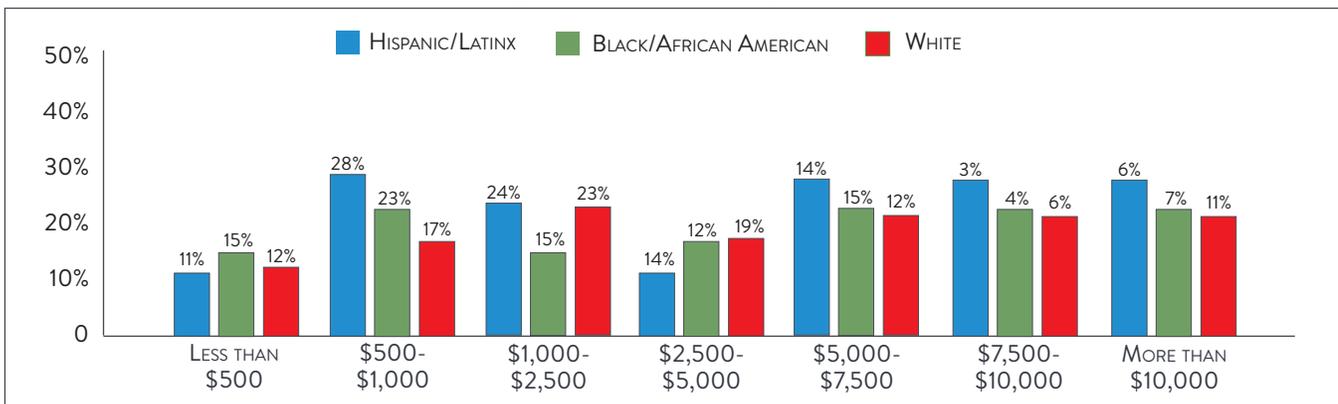
Percent with Medical Debt Amounts, by Income



Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Figure 2

Percent with Medical Debt Amounts, by Race and Ethnicity



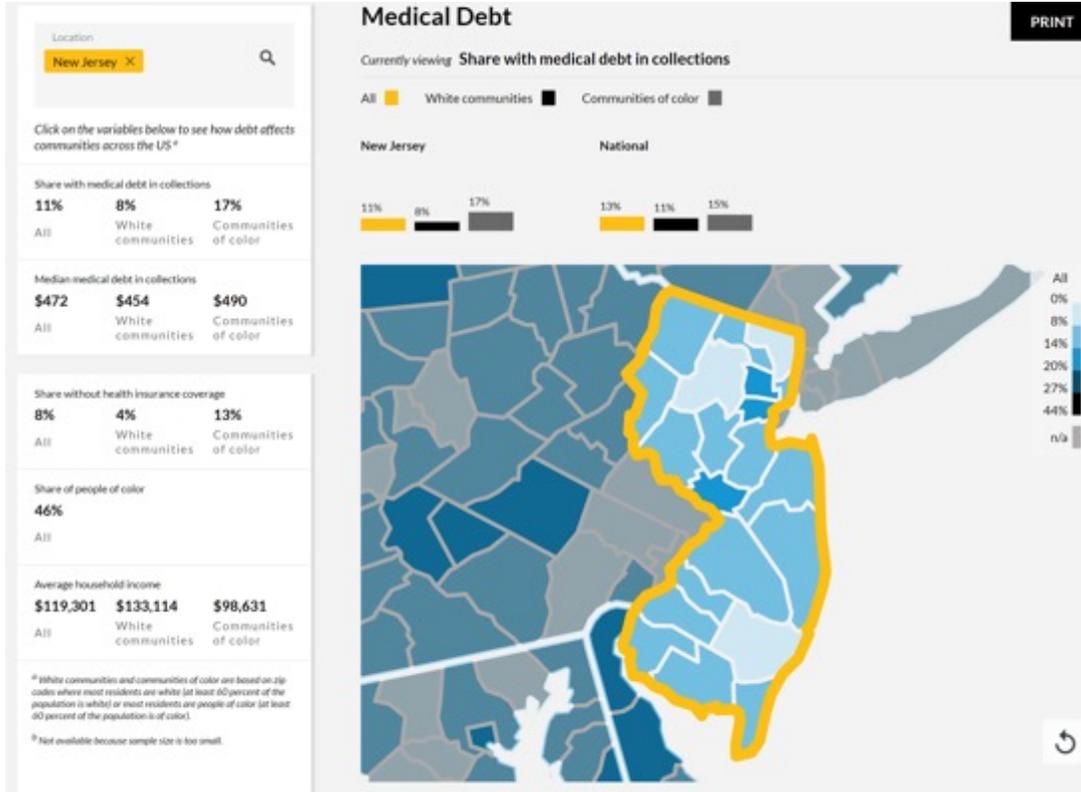
Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

It is well-documented that white households in the U.S. tend to have more wealth than Hispanic/Latinx and Black/African American households, which may increase the ability of white respondents to take on more medical debt.²⁰ Evidence also suggests that Hispanic/Latinx and Black/African American individuals are more likely to avoid care due to cost and other factors (such as trust in medical providers) than white individuals, which may impact their likelihood of accruing larger amounts of medical debt.^{21,22}

An analysis from the Urban Institute also reveals drastically different rates of medical debt across different racial communities in New Jersey.²³ Researchers found that 11% of New Jersey residents have medical debt in collections, compared to 13% of people nationwide (see Figure 3). New Jersey surpasses the national average, however, when it comes to medical debt in collections *among people of color*. Seventeen percent of communities of color in New Jersey have medical debt in collections, compared to 15% of communities of color nationwide. Moreover, the racial disparity in New Jersey is striking—8 percent of majority-white communities in New Jersey have medical debt in collections, compared to 17 percent of New Jersey communities of color.

Figure 3

Share of New Jersey Residents with Medical Debt in Collections, by Communities of Color and White Communities

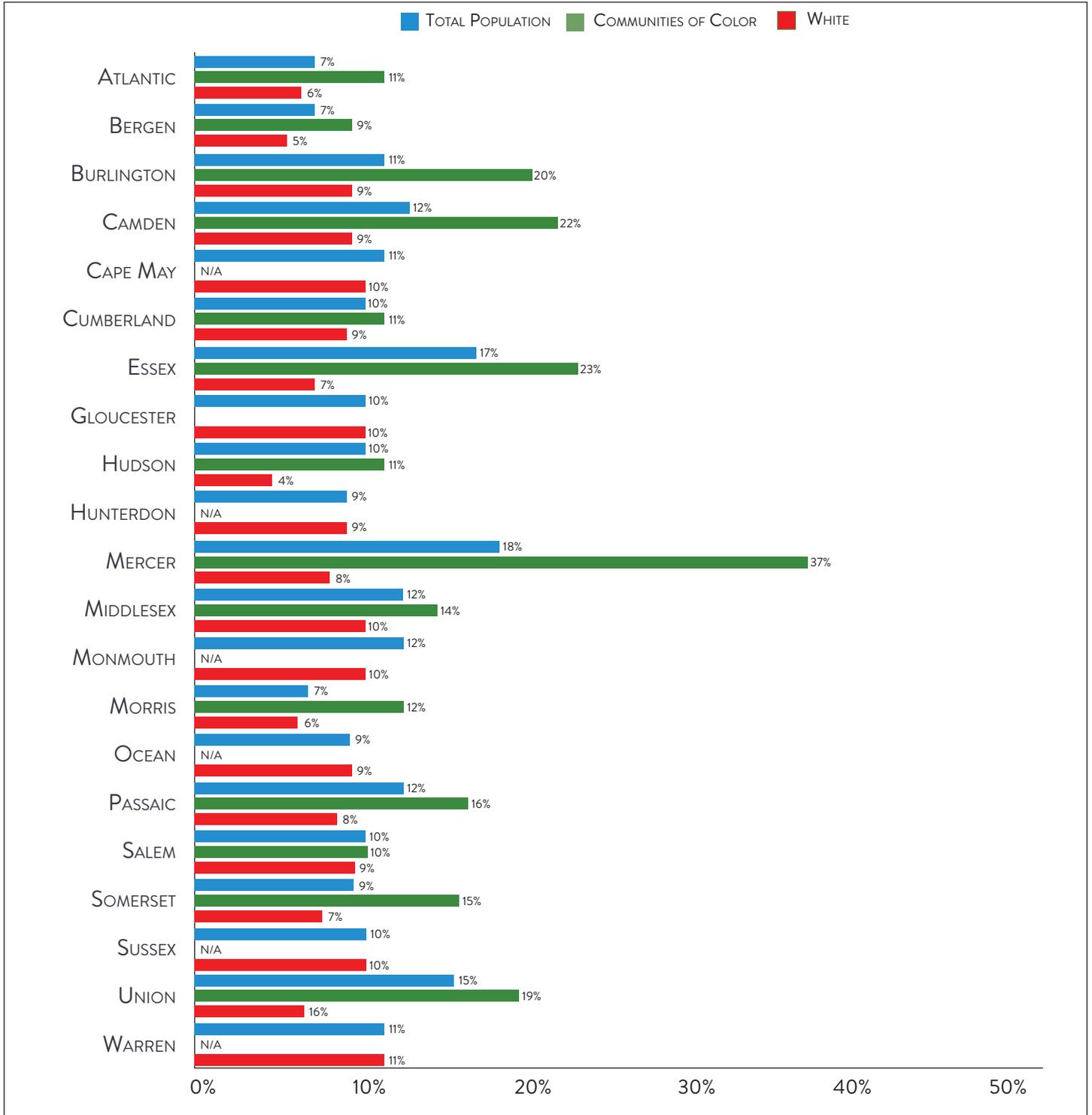


Source: *Debt in America: An Interactive Map, New Jersey Medical Debt, Urban Institute, (August 4, 2022).*
https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_med&state=34

The Urban Institute’s analysis also revealed *geographic* differences in the rates of medical debt in collections.²⁴ While the majority of New Jersey counties have 10-12% of their residents with medical debt in collections, three counties (Essex, Union and Mercer) have higher shares of residents reporting this problem (17%, 15% and 18%, respectively) (see Figure 4). Atlantic, Bergen, and Morris have the lowest shares of residents with medical debt in collections, at 7% each. In every county where data was available (all but seven), a larger share of communities of color had medical debt in collections than majority-white communities. In Mercer County, which has one of the highest shares of residents with medical debt in collections (at 18%), the share of residents of color with medical debt in collections was nearly 5 times larger than that of white residents (37% and 8%, respectively).

Figure 4

Share of Population with Medical Debt in Collections, by County and Race



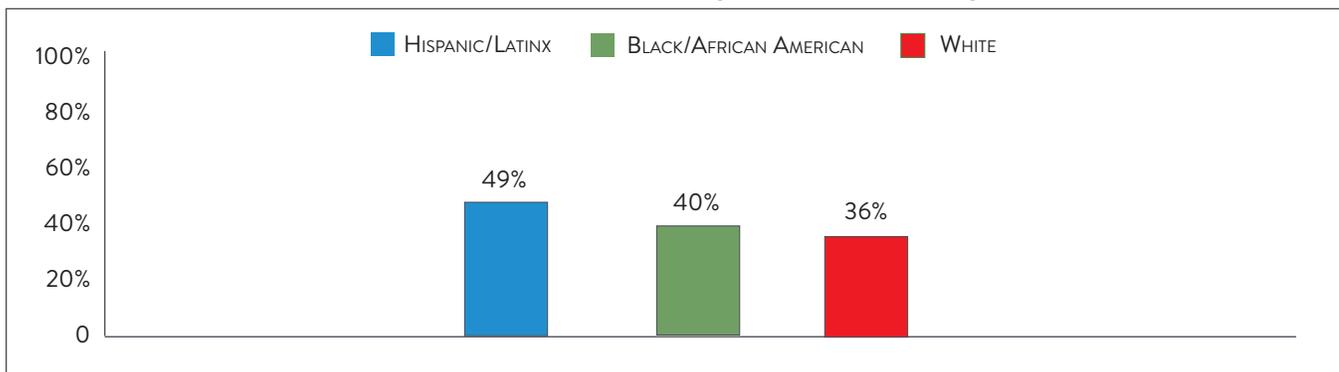
Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

IMPACT OF MEDICAL DEBT ON NEW JERSEYANS' HEALTH AND FINANCES

New Jerseyans with medical debt report forgoing needed care, daily necessities and saving for the future in order to repay some of their medical debt. More than one third of respondents to the Healthcare Value Hub's survey (36%) reported that their medical debt prevented them, or someone living with them, from seeking needed care.²⁵ Respondents identifying as Hispanic/Latinx were more likely than Black/African American respondents and white respondents to report going without care due to medical debt (see Figure 5).

Figure 5

Percent Avoided Needed Care Due to Medical Debt, by Race and Ethnicity



Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

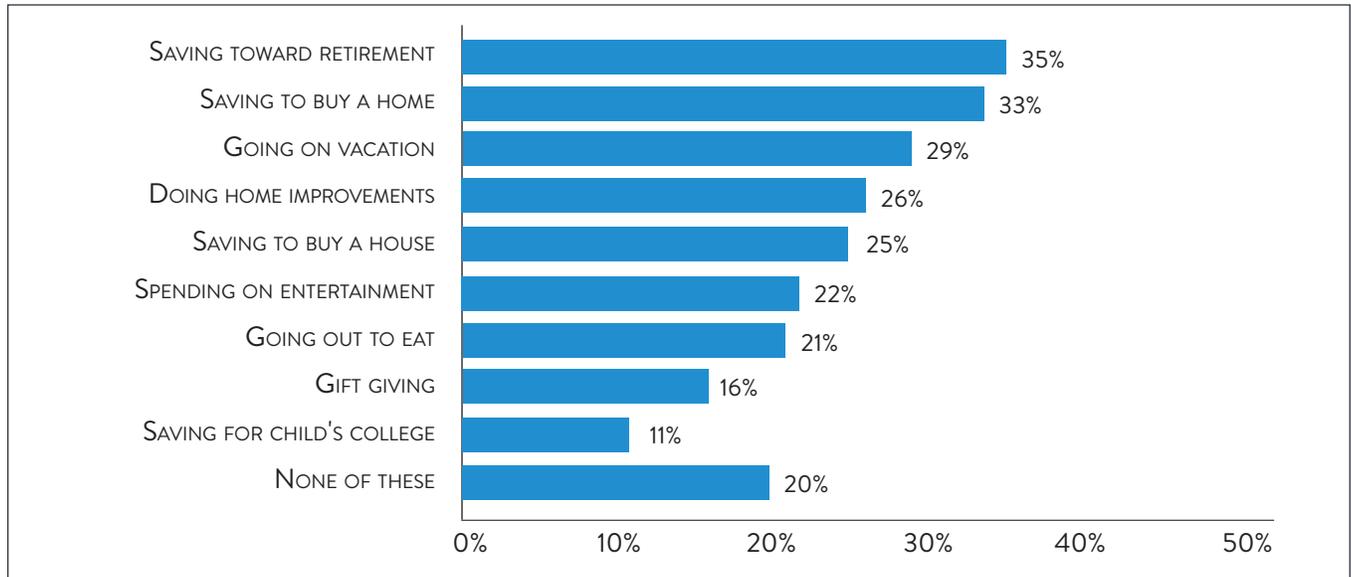
Medical debt is also forcing New Jerseyans to make difficult financial tradeoffs. Almost one third of respondents (29%) reported that their medical debt had prevented them from staying up-to-date on paying their bills (see Figure 5).²⁶ Of the 71% of respondents who had paid off at least some of their medical debt in the past year, almost 1 in 5 (19%) used money that was intended for necessities like food, heat or housing.

Medical debt is also making it difficult for New Jerseyans to save for the future. One in four respondents (25%) reported that medical debt has prevented them from saving to buy a house, while more than one third (35%) reported that medical debt has prevented them from saving for retirement. One in ten (11%) reported that medical debt has prevented them from saving for a child's college education (see Figure 6).²⁷ While similar percentages of respondents across racial/ethnic groups reported that medical debt has prevented them from saving for most future expenses, Hispanic/Latinx and Black/African Americans respondents more frequently reported that medical debt had prevented them from saving to buy a house—33% and 30%, respectively, compared to 23% of white respondents. This finding is particularly concerning given the significant racial and ethnic disparities in property ownership in the U.S. and the relationship between property ownership, generational wealth and the racial wealth gap.²⁸

New Jerseyans with medical debt also reported being subjected to aggressive debt collection tactics, such as wage and asset garnishment and being served lawsuits. Nineteen percent of respondents to the Healthcare Value Hub's survey who had medical bills in collections reported having their wages garnished in the past 12 months, while 17% reported having assets other than wages garnished and 16% reported being sued over their medical debt.

Figure 6

Percent of Respondents Whose Medical Deb Prevented the from Saving, Paying for Basic Necessities



Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

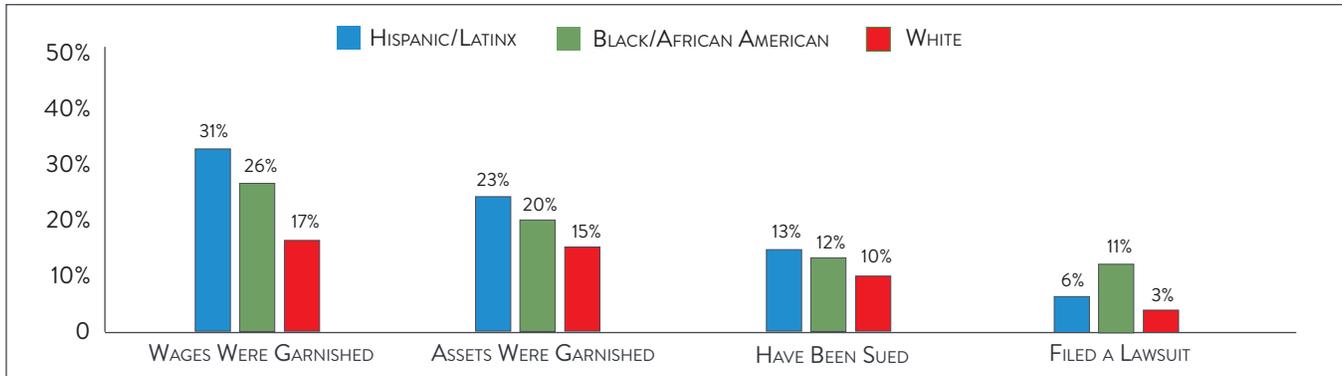
The survey also revealed that Black/African American and Hispanic/Latinx respondents were more likely to experience these aggressive medical debt collections tactics.²⁹ Roughly 1 in 3 Hispanic/Latinx respondents (31%) and 1 in 4 (26% of) Black/African American respondents reported having their wages garnished due to medical debt, compared to 17% of white respondents (see Figure 7). Similarly, 23% of Hispanic/Latinx respondents and 20% of Black/African American respondents reported having their assets seized due to medical debt, versus 15% of white respondents.

The higher prevalence of wage and asset garnishment among New Jerseyans of color is compounded by higher rates of uninsurance, lower earnings and less accumulated wealth among Black/African American and Hispanic/Latinx households compared to white households.³⁰ Each of these factors makes it difficult for people to tackle large amounts of medical debt, but even more so when combined.

These data demonstrate the magnitude of medical debt's impact on New Jersey residents and the disparities between communities in the state. Creating consumer protections surrounding medical debt would further New Jersey's health equity goals by ensuring that those who suffer disproportionately from medical debt are not financially ruined by their medical expenses.

Figure 7

Percent of Respondents with Garnishments and Lawsuits, by Race/Ethnicity



Source: 2022 Poll of New Jersey Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

WHAT IS CAUSING MEDICAL DEBT?

A confluence of factors contributes to the increasing incidence of medical debt in New Jersey. Rising healthcare costs, increasing insurance cost-sharing burdens and lack of consumer knowledge of charity care provisions converge to saddle consumers with bills they cannot pay, and, consequently, medical debt.

RISING HEALTHCARE COSTS AND INCREASED CONSUMER COST-SHARING

The U.S. spends more on healthcare as a share of the economy than other countries—in 2018, health spending accounted for 17.7% of the U.S. gross domestic product.^{31,32} However, this is not the sole cause of increasing out-of-pocket spending—health insurers are shifting costs to consumers through high deductible health plans, as well as higher coinsurance, co-pays and premiums.³³ Recent surveys reveal that healthcare affordability has become a major consumer concern.³⁴

Research reveals that the average premium for single and family coverage each increased by 4% from 2020-2021.³⁵ The average family premium has increased 47% since 2011 and 22% since 2016. Rates of workers with a general annual deductible also increased significantly, from 55% in 2006 to 85% in 2021.³⁶ Meanwhile, these deductibles themselves are also increasing—the average family deductible for a high deductible health plan jumped from \$3,511 in 2006 to \$4,705 in 2021.^{37,38}

On top of an annual deductible, 68% of covered workers have coinsurance and 12% have a copay that applies to inpatient hospital admissions.³⁹ The average coinsurance rate for a hospital admission is 20%, and the average copay amount is \$321. Among those who reported in 2016 that they had problems paying medical bills, 49% and 61% said their bills came from hospitalization and emergency room visits, respectively.⁴⁰

Shifting costs to consumers is impacting New Jersey residents. One third (33%) of Healthcare Value Hub survey respondents with medical debt reported that they incurred their debt, despite having insurance, because their deductible was too high and they were unable to meet it.⁴¹ Another 14% reported that they

incurred debt because their coinsurance was too high and they could not afford to pay it. Finally, almost half of survey respondents (49%) reported that they incurred medical debt because their insurance plan did not cover their medical service.

LACK OF CONSUMER KNOWLEDGE OF CHARITY CARE

Despite federal and state requirements for hospitals to disclose charity care opportunities, many New Jerseyans remain unaware of this option. Nonprofit hospitals are required to have programs to reduce or waive bills for eligible patients and to provide other community benefits.⁴² However, the Internal Revenue Service does not specify any quantity requirements for these benefits.^{43,44} In addition, though the Affordable Care Act requires nonprofit hospitals to provide charity care to eligible patients, it does not specify what criteria or amounts are considered appropriate.⁴⁵ The lack of guidance at the federal level leaves much policymaking power on charity care with state policymakers.

New Jersey’s charity care regulations are somewhat more generous than those in many other states. All acute care hospitals in the state must participate in the state’s Hospital Care Payment Assistance Program (charity care), though they are not required to adopt their own financial assistance policies (see Table 1). To be eligible for *no-cost* charity care for necessary services, a person must be uninsured or have insurance that covers only part of their bill, ineligible for private or governmental coverage *and* have a family income of less than or equal to 200% of the Federal Poverty Level (FPL).⁴⁶

Table 1
Income Criteria for New Jersey’s Hospital Care Payment Assistance Program

INCOME AS A PERCENTAGE OF HHS POVERTY INCOME GUIDELINES	PERCENTAGE OF CHARGE PAID BY PATIENT
LESS THAN OR EQUAL TO 200%	0%
GREATER THAN 200% BUT LESS THAN OR EQUAL TO 225%	20%
GREATER THAN 225% BUT LESS THAN OR EQUAL TO 250%	40%
GREATER THAN 250% BUT LESS THAN OR EQUAL TO 275%	60%
GREATER THAN 275% BUT LESS THAN OR EQUAL TO 300%	80%
GREATER THAN 300%	100%

Note: If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e., bill unpaid by other parties), the the amount in excess of 30% is considered hospital care payment assistance.

Source: *New Jersey Hospital Care Payment Assistance Fact Sheet*, New Jersey State Department of Health, February 2018. [https://www.nj.gov/health/charitycare/documents/NJ%20Charity%20Care%20Fact%20Sheet_Feb2018%20\(English\).pdf](https://www.nj.gov/health/charitycare/documents/NJ%20Charity%20Care%20Fact%20Sheet_Feb2018%20(English).pdf)

Eligible individuals with incomes between 200-300% FPL are eligible for charity care at a *reduced rate*, paying anywhere from 20-80% of the cost of their care.⁴⁷ New Jersey also requires the Department of Health to establish a sliding scale for hospital charges for individuals whose family gross income is less than 500% FPL, though these individuals must also be uninsured.

Many eligible patients remain unaware that they could qualify for such a program. Failure by hospitals to effectively explain charity care provisions results in unnecessary medical debt, often for those who can least afford it. The Healthcare Value Hub's survey revealed that hospitals are an important source of medical debt in New Jersey—sixty-one percent of surveyed New Jerseyans with medical debt reported that their medical debt came from a hospital, while 36% reported that it came from a doctor or technician *within* a hospital.⁴⁸ Of those respondents who incurred debt at a hospital, almost half of them (46%) reported that they believe that the hospital staff did not explain their financial assistance or charity care policies. Even more concerning, almost half (49%) of those without insurance, who are often eligible for charity care, reported not being aware of a hospital's financial assistance or charity care policies.

AGGRESSIVE BILLING AND COLLECTION PRACTICES

Across the country, hospitals and other debt collectors use aggressive tactics to recoup patients' medical debt, such as filing lawsuits against patients, acquiring garnishments on patient wages and assets and pursuing liens on patients' property. Investigative reports have documented how nonprofit hospitals brought lawsuits against patients with unpaid medical bills, even when those patients are lower-income.^{49,50} A 2020 analysis revealed that although almost all of the nation's largest hospitals and health systems halted legal action between 2019 and the first seven months of 2020, at least 16 pursued lawsuits, wage garnishments and liens against their patients during this time.⁵¹

The vast majority of those sued over their debts do not respond to court summons, ensuring automatic wins for plaintiffs and often, garnishment orders.⁵² Research indicates that garnishments across the U.S. are concentrated among lower-income and Black households.⁵³ New Jersey residents are not immune from these aggressive collection practices—almost 1 in 5 (19% of) New Jersey survey respondents with medical debt in collections reported having their wages garnished due to their medical debt in the past year, while 17% reported having their assets garnished. Larger percentages of Black/African American and Hispanic/Latinx respondents reported having their wages and assets garnished than white respondents (see Figure 7). Furthermore, over a quarter of respondents with medical debt in collections (27%) reported that their facility or provider sent their bill to collections just one month after they received their first bill.⁵⁴

Many of the New Jerseyans surveyed who have been sued report not understanding their legal rights. Over 1 in 10 respondents (11%) reported being sued over their medical debt in the past year, and 40% of respondents reported feeling that they do not understand their legal rights related to medical debt collection.⁵⁵ While national data show that most people who are sued over their debt do not respond to court summons, some New Jerseyans are fighting back against their medical debt lawsuits. Over three-quarters (76%) of survey respondents who had been sued over their medical debt reported challenging the lawsuits against them and the vast majority (89%) were successful. These statistics could indicate that more patients stand to benefit from challenging the medical debt lawsuits against them.

HOW STATE POLICYMAKERS CAN PROTECT CONSUMERS

While many look to the federal government for a solution to the medical debt crisis, there are concrete steps that state policymakers can take to ease consumer burden.

One of the most effective ways to reduce and prevent medical debt is to increase healthcare affordability by promoting policies that expand access to affordable coverage and directly lower consumer out-of-pocket costs. Policies include, but are not limited to: expanding access to Medicaid coverage for undocumented immigrants and low-income earners who are above current income eligibility limits; extending or increasing state Marketplace subsidies; and waiving or reducing cost-sharing for high-value services on Marketplace plans.⁵⁶

States can also directly target parts of the healthcare system that cause medical debt and those that negatively impact consumers with medical debt. Such policies include: requiring transparent and readily available hospital financial assistance policies; curtailing aggressive medical debt collection practices; and requiring reporting of population data for financial assistance and medical debt. This section describes recently passed state laws that target the increasing issue of medical debt; however, there are surely other policy avenues to be explored.

As of this writing, there are 21 states with laws to protect patients from medical debt—the strongest of these include Colorado, Illinois, Maryland and New Mexico (see Appendix A, Table 1).⁵⁷

TRANSPARENT AND READILY AVAILABLE HOSPITAL FINANCIAL ASSISTANCE POLICIES

Patients who are eligible for charity care are frequently unaware of such programs and can end up paying bills that should have otherwise been free or reduced.⁵⁸ Although New Jersey hospitals are required to provide all patients with an individual written notice of the availability of charity care and Medicaid the time of service (but no later than the issuance of the first billing statement), patients may not receive this information or may not understand it, as recent survey data confirm.^{59,60,61} Furthermore, the IRS requires nonprofit hospitals to translate their financial assistance policy documents into the languages spoken by every limited English proficiency group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital.⁶² However, hospitals may not always follow these requirements in every communication with patients.^{63,64,65}

As in **New Jersey**, other states require hospitals to screen uninsured patients to see if they are eligible for public assistance programs, such as Medicaid.⁶⁶ Some states have gone even further, mandating that hospital financial assistance policies and charity care be easier to understand and making it clear how patients can receive assistance or file complaints about the process.

For instance, in addition to requiring healthcare facilities to screen uninsured patients for public health insurance and financial assistance programs, **Colorado** also requires healthcare facilities to use a single uniform application that the Colorado Department of Health Care Policy and Financing developed, as well as a standardized notification of patients' rights.⁶⁷ This notification must include a written explanation at a sixth grade reading level that must be translated into any language that 10% of the county or state population speaks. These policies must also be posted on the Department of Health Care Policy and Financing's website, in each of these languages.

In addition to requiring hospitals to provide an opportunity for patients to be screened for and given assistance with applying for public health insurance programs, **Illinois** requires hospital financial assistance applications to direct uninsured patients to contact the hospital's financial counseling department if they need assistance.⁶⁸ These applications include language directing patients to address their complaints or concerns to the Attorney General, with a website, phone number or both provided by the Attorney General.

In **Maryland**, hospitals must calculate income eligibility for free care (to patients with family income at or below 200% FPL) or reduced-cost care *at the time of service* or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.⁶⁹ Hospitals must also provide notice of their financial assistance policy to the patient or their family before discharge and in each communication to the patient regarding collection of the bill.⁷⁰ Hospitals must also post a notice in conspicuous places throughout the hospital notifying patients of their right to apply for financial assistance. These notices must be in simplified language, at least 10-point type, and in the patient's preferred language or in each language spoken by a limited English proficient population that constitutes 5% of the overall population within the city or county, measured by the most recent Census.

CURTAIN AGGRESSIVE MEDICAL DEBT COLLECTION PRACTICES

News reports have recently focused on the aggressive collection actions that hospitals take, often to the detriment of their patients. These practices include selling patients' debt to collector services and beginning legal proceedings, such as garnishing patients' wages or taking out liens against patients' homes. **New Jersey** prohibits hospitals from sending bills for services or undergoing collection procedures against individuals determined to be eligible for charity care, and those eligible for reduced charity care may not be billed or subject to collection procedures for that portion of their bill.⁷¹ Unfortunately, recent survey data show that alarming numbers of New Jersey residents with medical debt have been subjected to these aggressive billing practices. Facing this same issue, other states have taken additional steps to curtail some of these collection tactics.

Colorado limits hospital bills for every resident at or below 250% FPL whose care does not qualify for discounted hospital care under the Colorado Indigent Care Program.⁷² The maximum amount that these facilities may charge uninsured patients will be set and published by the Colorado Department of Health Care Policy and Financing. In addition, monthly charges from hospitals for these services are not allowed to exceed 4% of a qualified patients' monthly income, while monthly charges for the hospital-based providers may not exceed 2% of that income. Colorado also mandates that bills for both insured and uninsured patients must be treated as paid in full after the patient makes 36 months of payments, and that hospitals permanently cease any collection activities on any remaining balance. In an effort to increase price transparency in 2022, Colorado passed a law prohibiting a hospital or entity collecting on behalf of a hospital from initiating or pursuing collection actions against a patient who incurred debt while the hospital was not in material compliance with federal hospital price transparency laws.⁷³

Maryland's recent Medical Debt Protection Act provides some of the strongest protections for consumers suffering from medical debt in the U.S., including:⁷⁴

- ▲ Prohibitions on arrests for medical debt and liens on primary residences for all patients;
- ▲ Prohibitions on wage garnishment for low-income patients eligible for free or reduced-cost care; and
- ▲ Requirements for hospitals to offer income-based repayment plans.

Importantly, until these repayment plans are in place, medical debt lawsuits are prohibited for all patients, allowing some reprieve until the law fully takes effect. The Health Service Cost Review Committee is charged with developing guidelines for what these repayment plans should look like.

New Mexico prohibits healthcare facilities, third-party healthcare providers and medical creditors from pursuing collection actions⁷⁵ against patients with incomes at or below 200% FPL over charges for healthcare services and medical debt.⁷⁶ The broad definition of healthcare facilities covered by this law includes most healthcare facilities licensed by the State Department of Health, as well as urgent care centers or freestanding emergency rooms. However, the onus is on the patients, who must request an “indigency determination.”

REPORT POPULATION DATA FOR FINANCIAL ASSISTANCE AND MEDICAL DEBT

As more states pass hospital financial assistance laws, many are also incorporating population reporting requirements. Such metrics help policymakers understand the impact of medical debt on their residents and view trends across populations. These metrics are sometimes housed within a state’s community benefit requirements for hospitals. Implementing these reporting requirements is a step towards understanding the equity concerns surrounding medical debt. **New Jersey** currently requires all acute care hospitals to submit the following demographic information about patients who qualify for charity care or to whom the hospital provides uncompensated care: age, sex and type of health insurance, as well as information on their marital and employment status.^{77,78} Notably, New Jersey does not require the collection of racial/ethnic information or languages spoken within charity care claims.

Colorado requires healthcare facilities to report annually on patient demographic data (race, ethnicity, age and primary language spoken) to evaluate their compliance with required screening, discounted care, payment plan and collections practices.⁷⁹ **Maryland** similarly requires acute care and chronic care hospitals to report the race or ethnicity, gender and zip code of patients against whom the hospital or their debt collector has filed an action to collect on a hospital bill. These facilities must also report the race or ethnicity, gender and zip code of patients to whom the hospital has and has not reported or classified a bad debt. Maryland hospitals must also report the total dollar amount of the charges for hospital services provided to patients, but not collected by the hospital, for both patients with and without insurance, including their out-of-pocket costs.⁸⁰

Illinois has included reporting on hospital financial assistance within their community benefits plans. Each nonprofit hospital must prepare an annual report of their community benefits plan, which must include a disclosure of the amount and type of community benefits actually provided, including charity care and details about financial assistance applications received and processed by the hospital.⁸¹ Hospitals must make these plan reports public by publishing the information on their website. This information must include: the number of applications submitted to the hospital, complete and incomplete; the number of applications approved; the number of applications denied, and the 5 most frequent reasons for denial. To the extent that race, ethnicity, sex or preferred language is collected and available for financial assistance applications, these data must be reported along those categories.

CONCLUSION

Medical debt is an increasing problem for consumers across the U.S., and New Jersey is no exception. The trend of shifting increasing amounts of ever-higher healthcare costs onto consumers places large affordability burdens on New Jerseyans seeking care. As a result, many New Jerseyans avoid getting needed medical care, but many also go into medical debt. Although medical debt impacts different communities in different ways, it is clearly a problem for large swaths of New Jersey consumers.

Much of New Jersey survey respondents' debt stemmed from hospitals. New Jerseyans who do incur medical debt find themselves on the receiving end of aggressive billing tactics, and often forgo care, daily necessities or future financial security to pay off some of their medical debt. Policymakers in the state should look to existing protective legislation in other states as examples, and work to protect New Jerseyans by making care more affordable and guarding against the worst impacts of medical debt.

NOTES

1. Bennett, Neil, et al., *Who Had Medical Debt in the United States?*, U.S. Census Bureau (April 7, 2021). <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>
2. Kluender, Raymond, et al., "Medical Debt in the US, 2009-2020," *JAMA*, Vol. 326, No. 3 (July 20, 2021). <https://jamanetwork.com/journals/jama/article-abstract/2782187>
3. Stebbins, Samuel, "How Many People in New Jersey Are Burdened with Medical Debt?," *Patch*, (April 2, 2020). <https://patch.com/new-jersey/across-nj/how-many-people-new-jersey-are-burdened-medical-debt>
4. Blumberg, Dave, *Equifax, Experian, and TransUnion Support U.S. Consumers With Changes to Medical Collection Debt Reporting*, TransUnion Newsroom (March 18, 2022). <https://newsroom.transunion.com/equifax-experian-and-transunion-support-us-consumers-with-changes-to-medical-collection-debt-reporting/>
5. *Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection*, The White House (April 11, 2022). <https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/>
6. Adler, Loren, et al., *Understanding the No Surprises Act*, USC-Brookings Schaeffer on Health Policy, (Feb. 4, 2021). <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/>
7. Lopes, Lunna, et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, Kaiser Family Foundation, (June 16, 2022). <https://www.kff.org/health-costs/report/kff-health-care-debt-survey/>
8. The Census Bureau used the phrase, "households with a Black householder," "households with a Hispanic householder," and "households with an Asian householder." We have slightly modified this language for ease of reading.
9. Bennett, Neil, et al., *Who Had Medical Debt in the United States?* U.S. Census Bureau, (April 7, 2021). <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>
10. *Debt in America: An Interactive Map – Debt Delinquency, New Jersey*, Urban Institute, (March 31, 2021). https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=pct_debt_collections&state=34
11. Bennet, Neil, et al. (2021).
12. Creamer, John, *Poverty Rates for Blacks and Hispanics Reached Historic Lows in 2019*, U.S. Census Bureau, (Sept. 15, 2020). <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html>
13. Hill, Latoya, et al., *Key Facts on Health and Health Care by Race and Ethnicity*, Kaiser Family Foundation, (Jan. 26, 2022). <https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-coverage-and-access-to-and-use-of-care/>
14. Hamel, Liz, et al., *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, Kaiser Family Foundation (January 2016). <https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>

15. [Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance](#), Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
16. Ibid.
17. [Debt in America: An Interactive Map](#), (March 31, 2021).
18. [Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance](#), Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
19. Ibid.
20. Aladangady, Aditya, and Akila Forde, *FEDS Notes: Wealth Inequality and the Racial Wealth Gap*, Board of Governors of the Federal Reserve System, (Oct. 22, 2021). <https://www.federalreserve.gov/econres/notes/feds-notes/wealth-inequality-and-the-racial-wealth-gap-20211022.htm>
21. Kearney, Audrey, et al., *Americans' Challenges with Health Care Costs*, Kaiser Family Foundation, (Dec. 14, 2021). [https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=About%20six%20in%20ten%20Black,49%25\)%20of%20White%20adults.](https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=About%20six%20in%20ten%20Black,49%25)%20of%20White%20adults.)
22. Richmond, Jennifer, *What Can We Do About Medical Mistrust Harming Americans' Health?* Interdisciplinary Association for Population Health Science, (Accessed June 16, 2022). <https://iaphs.org/can-medical-mistrust-harming-americans-health/>
23. *Debt in America: An Interactive Map – Share with Medical Debt in Collections*, New Jersey, Urban Institute (March 31, 2021). https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_med&state=34
24. Ibid.
25. [Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance](#), Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
26. Ibid.
27. Ibid.
28. Ray, Rashawn, et al., *Homeownership, Racial Segregation, and Policy Solutions to Racial Wealth Equity*, Brookings Institute, (Sept. 1, 2021). <https://www.brookings.edu/essay/homeownership-racial-segregation-and-policies-for-racial-wealth-equity/>
29. [Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance](#), Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
30. <https://www.njpp.org/publications/report/new-jerseys-uninsured-getting-the-garden-state-covered/>
31. <https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/>
32. <https://www.cdc.gov/nchs/fastats/health-expenditures.htm>
33. *2021 Employer Health Benefits Survey*, Kaiser Family Foundation, (Nov. 10, 2021). <https://www.kff.org/report-section/ehbs-2021-section-1-cost-of-health-insurance/>
34. *Consumer Healthcare Experience State Survey*, Healthcare Value Hub (Accessed Sept. 2, 2022). <https://www.healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey>
35. Ibid.
36. Ibid.
37. This refers to high-deductible health plans with a savings option and aggregate structure.
38. The average family deductible for an HMO plan (with aggregate structure) increased from \$751 in 2006 to \$3,400 in 2021, and the average family deductible for a PPO plan (with aggregate structure) increased from \$1,034 in 2006 to \$3,000 in 2021.
39. *2021 Employer Health Benefits Survey (2021)*.
40. Hamel et al., (2016).
41. [Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance](#), Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
42. Bai, Ge, et al., “Analysis Suggests Government and Nonprofit Hospitals’ Charity Care is Not Aligned with Their Favorable Tax Treatment,” *Health Affairs*, Vol. 40, No. 4, (April 2021). <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01627>

43. *Charitable Hospitals – General Requirements for Tax-Exemption Under Section 501(c)(3)*, Internal Revenue Service, (Accessed June 21, 2022). <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>
44. There is some evidence that nonprofit hospitals are shirking their charity care obligations. A 2021 study found that nonprofit hospitals spent \$2.3 of every \$100 in total expenses incurred on charity care, which was less than both government and for-profit hospitals, \$4.1 and \$3.8, respectively. See: Bai, Ge, et al. (2021).
45. *Charitable Hospitals – General Requirements for Tax-Exemption Under Section 501(c)(3)*, Internal Revenue Service, (Accessed June 21, 2022). <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>
46. *New Jersey Charity Care Regulations and Public Notices*, New Jersey Department of Health, (Accessed June 21, 2022). <https://www.state.nj.us/health/charitycare/regs-public-notice/>
47. If qualified medical expenses of individuals eligible for charity care exceed 30% of their annual gross income, the excess will be eligible for 100% coverage under charity care.
48. *Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance*, Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
49. Miller, Maya, and Beena Raghavendran, “Thousands of Poor Patients Face Lawsuits from Nonprofit Hospitals That Trap Them in Debt,” *ProPublica* (Sept. 13, 2019). <https://www.propublica.org/article/thousands-of-poor-patients-face-lawsuits-from-nonprofit-hospitals-that-trap-them-in-debt>
50. Dunker, Amanda, and Elisabeth Ryden Benjamin, “Discharged into Debt: New York’s Nonprofit Hospitals are Suing Patients,” *Community Service Society*, (March 2020). <https://www.cssny.org/publications/entry/discharged-into-debt>
51. Deam, Jenny, “Some Hospitals Kept Suing Patients Over Medical Debt Through the Pandemic,” *ProPublica*, (June 14, 2021). <https://www.propublica.org/article/some-hospitals-kept-suing-patients-over-medical-debt-through-the-pandemic>
52. Lucas McKay, Katherine, et al., *Consumer Debt – A Primer, The Aspen Institute’s Expanding Prosperity Impact Collaborative*, (March 26, 2018). <https://www.aspeninstitute.org/publications/consumer-debt-primer/>
53. Ibid.
54. *Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance*, Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
55. Ibid.
56. *2021 Healthcare Affordability State Policy Scorecard Summary Report*, *Healthcare Value Hub*, (January 2022). https://www.healthcarevaluehub.org/application/files/7416/4149/2069/2021_Healthcare_Affordability_Scorecard_-_Summary_Report.pdf
57. Robertson, Christopher T., et al., “New State Consumer Protections Against Medical Debt,” *JAMA*, Vol. 327, No. 2, (Jan. 11, 2022). <https://jamanetwork.com/journals/jama/article-abstract/2787901>
58. Rau, Jordan, “Patients Eligible for Charity Care Instead Get Big Bills,” *Kaiser Health News*, (Oct. 14, 2019). <https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/>
59. New Jersey Administrative Code 10:52-11.5, *New Jersey Charity Care Requirements*, LexisNexis, (Accessed June 21, 2022).
60. Pisacreta, Emily, “How to Crush Medical Debt: 5 Tips for Using Hospital Charity Care,” *Kaiser Health News*, (Oct. 15, 2021). <https://khn.org/news/article/how-to-crush-medical-debt-5-tips-for-using-hospital-charity-care/>
61. *Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance*, Data Brief No. 126, Altarum Healthcare Value Hub (September 2022).
62. *Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4)*, Internal Revenue Service, (Accessed June 21, 2022). <https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4>
63. Young, Bob, “Report: Washington Hospitals Stingy with Charity Care, with Language Barrier an Issue,” *Seattle Times*, (Sept. 12, 2017). <https://www.seattletimes.com/seattle-news/report-washington-hospitals-stingy-with-charity-care-with-language-barrier-an-issue/>
64. Tabora, Noah, “Spanish-Speaking Kansans Face Language Barrier Amid COVID-19,” *Kansas Reflector*, (Aug. 30, 2020). <https://kansasreflector.com/2020/08/30/spanish-speaking-kansans-face-language-barrier-amid-covid-19/>
65. Heath, Sara, “Low-Income Patients Cite Financial, Cultural Barriers to Care,” *Patient Engagement Hit*, (Jan. 18, 2017). <https://patientengagementhit.com/news/low-income-patients-cite-financial-cultural-barriers-to-care>

66. New Jersey Administrative Code § 10:52-11.5, Case Text, (Accessed Aug. 4, 2022). <https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-52-hospital-services-manual/subchapter-11-charity-care/section-1052-115-charity-care-screening-and-documentation-requirements>
67. *Colorado House Bill 21-1198: Health-care Billing Requirements for Indigent Patients*, (2021 Regular Session), Colorado Legislature, (Accessed June 21, 2022). <https://leg.colorado.gov/bills/hb21-1198>
68. *Illinois Senate Bill 1840: Amends the Community Benefits Act, (2021-2022 Session)*, LegiScan, (Accessed June 21, 2022). <https://legiscan.com/IL/text/SB1840/2021>
69. *Maryland Senate Bill 514: Health Facilities – Hospitals – Medical Debt Protection*, (2021 Regular Session), Maryland Legislature, (Accessed June 21, 2022).
70. *Maryland House Bill 1420: Hospitals – Financial Assistance Policies and Bill Collections*, (2020 Regular Session), LegiScan, (Accessed June 21, 2022). <https://legiscan.com/MD/text/HB1420/id/2173398>
71. New Jersey Administrative Code § 10:52-11.14, Case Text, (Accessed Aug. 4, 2022). <https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-52-hospital-services-manual/subchapter-11-charity-care/section-1052-1114-collection-procedures-and-prohibited-action>
72. *Colorado House Bill 21-1198: Health-care Billing Requirements for Indigent Patients*, (2021 Regular Session), Colorado Legislature, (Accessed June 21, 2022). <https://leg.colorado.gov/bills/hb21-1198>
73. *Colorado House Bill HB22-1285L Prohibit Collection Hospital Not Disclosing Prices*, (2022 Regular Session), Colorado Legislature, (Accessed Aug. 4, 2022). <https://leg.colorado.gov/bills/HB22-1285>
74. *Maryland Senate Bill 514: Health Facilities – Hospitals – Medical Debt Protection*, (2021 Regular Session), Maryland Legislature, (Accessed June 21, 2022). <https://mgaleg.maryland.gov/2021RS/bills/sb/sb0514T.pdf>
75. Collections actions refers to selling debt and filing lawsuits to collect debt.
76. *New Mexico Senate Bill 71: Patients’ Debt Collection Protection Act, (2021 Regular Session)*, New Mexico Legislature, (Accessed June 21, 2022). <https://www.nmlegis.gov/Legislation/Legislation?Chamber=S&LegType=B&LegNo=71&year=21>
77. *New Jersey Administrative Code § 8:31B-4.40*, LexisNexis, (Accessed Aug. 4, 2022).
78. New Jersey Revised Statutes § 26:2H-18.59c (2014), Justia, (Accessed Aug. 4, 2022). <https://law.justia.com/codes/new-jersey/2014/title-26/section-26-2h-18.59c/>
79. *Colorado House Bill 21-1198: Health-care Billing Requirements for Indigent Patients*, (2021 Regular Session), Colorado Legislature, (Accessed June 21, 2022). <https://leg.colorado.gov/bills/hb21-1198>
80. *Maryland Senate Bill 514: Health Facilities – Hospitals – Medical Debt Protection*, (2021 Regular Session), Maryland Legislature, (Accessed June 21, 2022). <https://mgaleg.maryland.gov/2021RS/bills/sb/sb0514T.pdf>
81. *Illinois Senate Bill 1840: Amends the Community Benefits Act, (2021-2022 Session)*, LegiScan, (Accessed June 21, 2022). <https://legiscan.com/IL/text/SB1840/2021>



ABOUT THE HUB

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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APPENDIX A

Table 1
Comparison of Federal and Some Recent State Laws Protecting Patients from Medical Debt

	US Affordable Care Act IRC §501(r), eff. 12/29/2015	Colorado HB 1198 (2021), eff. 6/1/2021	Illinois SB 1840 (2021), eff. 1/1/2021	Maryland HB 565 (2021), eff. 1/1/2022	New Mexico SB 71 (2021), eff. 7/1/2021
Applicability					
Non-profit hospitals	✓	✓	✓	✓	✓
All hospitals	X	✓	✓	✓	✓
Collection agents	X	✓	✓	✓	✓
Other health care entities ^a	X	✓	X	✓	✓
Limits on billing					
Eligibility standards for free care (of FPL)	X	X	✓ (<200%)	✓ (<200%)	X
Standards for discounted care (of FPL)	X	✓ (<250%)	✓ (200%-600%)	✓ (200%-500%)	X
Links charges to public or private insurance rates ^b	✓	✓	✓	X	X
Payment plans capped ^c	X	✓	✓	✓	X
Limits on collection^d					
Limits when debt may be reported or sold	✓	✓	✓	✓	✓
Protects patient residence	X	✓	X	✓	✓
Limits wage garnishment	X	X	X	✓	✓
Other limits ^c	✓	X	✓	✓	✓
Enforcement					
Administrative enforcement ^f	✓	✓	✓	X	✓
Private right of action	X	✓	X	X	✓
Data reporting					
Reporting on financial assistance ^g	✓	✓	✓	✓	✓
Reporting on collection actions	X	✓	X	✓	X
Data collection by race, ethnicity, sex, primary language	X	✓ ^h	✓	✓	X

^aColorado’s law applies to outpatient departments and freestanding emergency departments. Maryland’s law applies to chronic care hospitals. New Mexico’s law applies to urgent care centers, freestanding emergency departments.

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Source: Robertson et al., “New State Consumer Protections Against Medical Debt,” JAMA, (Jan. 11, 2021). <https://jamanetwork.com/journals/jama/article-abstract/2787901>

APPENDIX B

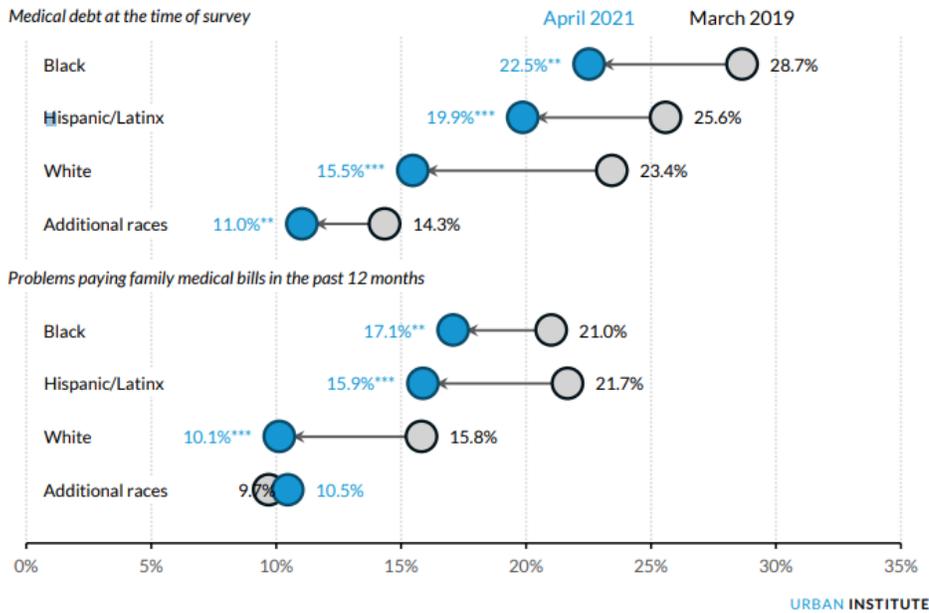
THE IMPACT OF COVID-19 ON MEDICAL DEBT, NATIONWIDE

Recent data from the Urban Institute reveals that the national prevalence of medical debt decreased during the COVID-19 pandemic. The percentage of non-elderly adults reporting medical debt decreased from 23.6% in March 2019 to 16.8% in April 2021 and the those reporting problems paying family medical bills in the prior 12 months declined from 17% to 12.2% over the same period.¹ The share of adults whose medical debt in collections is reflected on their credit reports also decreased, from 15.3% in February 2020 to 13.9% in August 2021.²

Although levels of medical debt declined for all racial and ethnic groups, disparities persisted (see Figure 1). Although the share of Black adults with medical debt decreased from 2019 to 2021, they continued to experience a higher rate of medical debt than other racial/ethnic groups (at 22.5%), followed by Hispanic/Latinx adults (19.9%) and white adults (15.5%).³ White adults experienced the largest decline in the prevalence of medical debt during the measured period.

Figure 1

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



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.

Researchers posit that the decline in medical debt resulted from a number of factors, including the well-documented trend of reduced healthcare usage nationwide, caused by families seeking to reduce expenditures, medical professionals limiting services and people avoiding care to avoid COVID-19 exposure.⁴ Expansions in Medicaid eligibility and policies increasing Marketplace enrollment likely also played a role, providing coverage for more individuals seeking care and, thus, some level of protection against medical debt. Other financial relief efforts such as increased nutritional assistance, expanded unemployment benefits, stimulus payments, eviction moratoriums and student loan freezes also likely contributed to overall increased financial health for families, allowing them to cover healthcare expenses.

Unfortunately, researchers do not expect the recent decline in medical debt to persist.⁵ Most of the temporary relief measures at both the federal and state levels have expired, and the postponement of Medicaid disenrollment required by the Families First Coronavirus Response Act will end with the public health emergency designation. While the recent decision of the three major credit reporting agencies to remove most medical debt in collections from credit reports, thereby lessening the impact of medical debt on people's overall economic well-being, providers an important consumer protection, it will not impact the prevalence of medical debt.

NOTES

1. Karpman, Michael, et al., Medical Debt Fell During the Pandemic. How Can the Decline be Sustained? Urban Institute, (May 11, 2022). https://www.urban.org/research/publication/medical-debt-fell-during-pandemic-how-can-decline-be-sustained?utm_medium=urban_newsletters&utm_source=news-UIU&utm_term=URBAN
2. Ibid.
3. Ibid.
4. Ibid.
5. Ibid.