Medical Debt in the United States

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Medical debts are unlike many other forms of debt. Individuals may not choose to incur them as they do with other financial obligations. Moreover, they reflect broader features of the U.S. health care system that attract justifiable criticism. Health care is expensive and insurance coverage incomplete. In the extreme, some segments of the health care market work particularly poorly and systematically generate unexpected balance bills that likely represent some of the most vexing medical debts.[1] Taken together, it is understandable that medical debts attract particular attention.

In my testimony, I will first summarize facts about medical debts in the United States, with particular attention paid to medical collections—one important type of medical debt which reflects health care bills that have been unpaid and sent to a collections agency. I will then outline the mechanisms through which these types of debts can affect individual personal finances more broadly. Finally, I will discuss the relative merits of policy proposals that would seek to reduce the influence of these debts, with an emphasis on recent developments in credit reporting. I will emphasize a few key points.

First, while some medical debts surely reflect unexpected health shocks, many likely do not. Medical collections average roughly $300 and are most common among populations where health care utilization is relatively low (notably younger adults). These empirical realities are important for understanding the causes of debt and merits of potential interventions. In particular, they suggest that many medical debts likely reflect an interaction between the generally high cost of health care and relatively tenuous financial state of some consumers.

Second, medical debt on credit profiles can affect consumers' financial health by raising their cost of borrowing or by causing them to divert resources from other obligations. However, real world empirical evidence suggests that policies which starkly reduce medical debt have inconsistent effects on broader financial health. In part, this likely reflects the low repayment rates and persistence of medical debt on credit profiles and is helpful for forecasting the potential effects of policy interventions.

Finally, policymakers should note that efforts to reduce the influence of medical collections will incentivize lenders to adjust behavior in ways that may threaten the intended goals of a policy. I outline a few margins on which compensatory behavior is most likely and discuss their potential impacts on lending markets.

The state of medical debt in the United States
Medical debt is a common form of personal debt in the United States. Roughly 16-18 percent of credit reports include medical collections—bills from health care providers which have gone unpaid,

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[1] E.g., Hyman, D., & Ippolito, B. N. (2019). Solving surprise medical billing. *AEI Economic Perspectives.*

sent to a collection agency, and reported to a national credit reporting agency—on which Americans owe roughly $88 billion.[2] The total value of medical collections on credit profiles has, however, fallen over the last decade or so.[3]

In my testimony, I will place particular emphasis on medical debts in collections. This is a very important form of medical debt that can be clearly and objectively measured. It has also been the focus of considerable research and is the focus of recent policy changes by credit bureaus. However, medical collections are not an exhaustive measure of total medical debt. Consumers might, for example, finance a health care bill on their credit card and be unable to pay the resulting balance (this would instead manifest in other outcomes, like higher credit card utilization). Surveys which ascertain information about medical debts more broadly often indicate higher debt levels. For example, one recent survey indicated that consumers held at least $195 billion in medical debt.[4]

Characterizing the relative importance of medical debts in household finances depends, in part, on the relevant context. On one hand, medical collections represent a small portion of aggregate household debt levels, which total over $15 trillion (or $4.5 trillion in non-mortgage debt).[5] Medical collections, however, are common when compared to debts of similar types. Notably, medical collections represent a slight majority of all collection tradelines on consumer credit profiles.[6]

While these aggregate data are useful, understanding the composition of individual debts is important for clarifying the likely causes and consequences of medical debt.

In short, medical collections are likely more common and more modestly sized than many might imagine. In particular, while some collections can be in the thousands of dollars, the median individual medical collection averages just over $300 (figure 1). Combined with the relatively large share of consumers who incur such collections, the data suggest that many medical debts in collections are incurred from relatively "typical" interactions with the health care system rather than rarer catastrophic events.

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[2] While precise estimates vary across studies, results are broadly consistent. The CFPB (2022) estimates $88 billion in collections. Batty, Gibbs, and Ippolito (2018) estimate that 16 percent of consumers had medical collections on their credit report, which totaled $81 billion in 2016. Kluender, Mahoney, and Wong (2021) estimate a prevalence of 17.8% and a total value of $140 billion (the larger dollar estimate largely owing to a bigger implied universe of credit accounts). Slightly earlier analysis from the CFPB indicated that 19.5 percent of consumer credit reports contained a medical collection. See Consumer Financial Protection Bureau. 2022. Medical Debt Burden in the United States. Batty, M., Gibbs, C., & Ippolito, B. (2018). Unlike medical spending, medical bills in collections decrease with patients' age. *Health affairs*, *37*(8), 1257-1264. Kluender, R., Mahoney, N., Wong, F., & Yin, W. (2021). Medical Debt in the US, 2009-2020. *JAMA*, *326*(3), 250-256. Consumer Financial Protection Bureau. 2014. Consumer credit reports: A study of medical and non-medical collections.
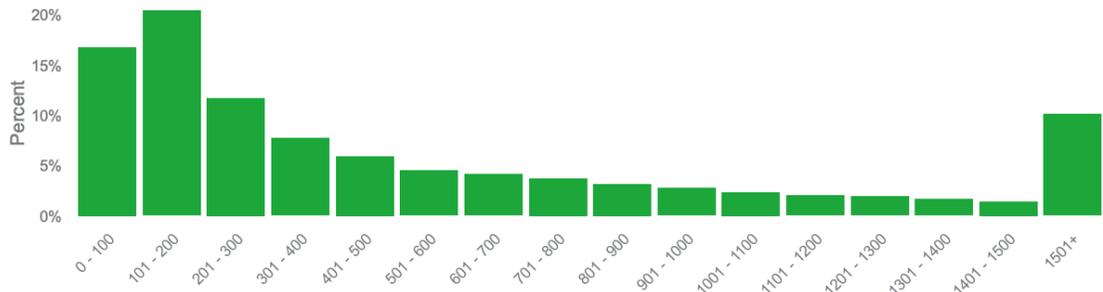
[3] E.g., Kluender, R., Mahoney, N., Wong, F., & Yin, W. (2021).

[4] Rae, M., Claxton, G., Amin, K., Wager, E., Ortaliza, J., and Cox, C. 2022. The burden of medical debt in the United States.

[5] Federal Reserve Bank of New York. Quarterly report on household debt and credit 2021:Q3

[6] CFPB (2022)

Figure 1: Distribution of medical collections balances in consumer credit panel, 2020. Reproduced from CFPB (2022).


Distribution of medical collections balance amounts (in dollars) in the CFPB's Consumer Credit Panel as of 2020.

In addition, the distribution of medical debt is highly uneven across geography and individuals. Notably, the highest frequency of medical collections is found among relatively young adults (figure 2), where health care expenditures are lower but where other important factors, like assets, are as well. Heterogeneity in insurance coverage across people and places clearly plays a role in these trends but does not fully explain observed debt patterns.[7]

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[7] E.g., Goldsmith-Pinkham, P., Pinkovskiy, M., & Wallace, J. (2021). The Great Equalizer: Medicare and the Geography of Consumer Financial Strain. Working paper. Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics*.

Figure 2: Percent of consumers with any new medical collections and the median size of their debt, by age, 2016. Reproduced from Batty, Gibbs, and Ippolito (2018).
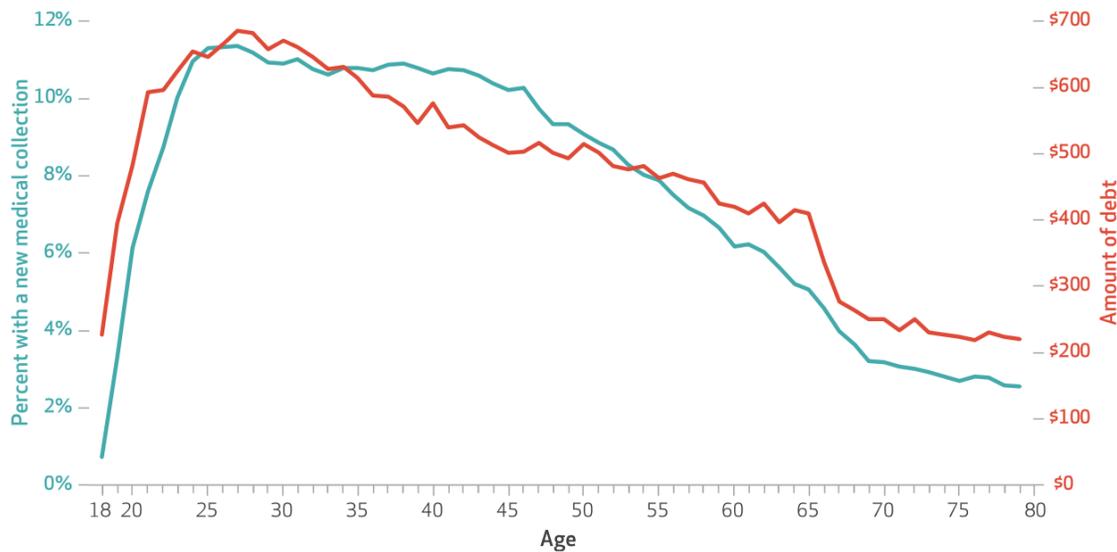
SOURCE Authors' analysis of data for 2016 from the Consumer Financial Protection Bureau's Consumer Credit Panel. **NOTE** *Medical collections* are defined as outstanding bills that have been reported to a nationwide credit reporting agency as a collection, with an original creditor classification code for medical or health care.

The role of medical debts in broader personal finances

The presence of medical debts, particularly when included on credit reports, can have important implications for consumers. Perhaps most directly, collections can enter negatively into credit scoring models. The appearance of a new medical collection can thereby reduce a consumer's credit score and affect their ability and cost of borrowing.

The credit consequences of medical debts are larger in settings where lenders employ older credit scoring models which typically give more weight to medical collections. Newer credit models treat medical debts less punitively in a few ways. Many newer models no longer include medical collections which were ultimately paid under the assumption that consumers who do so represent a lower credit risk than those who do not (this is a particularly sensible assumption if lenders believe some portion of these debts reflect individuals' confusion over appropriate payment of a health care bill).[8] In addition, unpaid medical collections are often given less weight than in prior models. This is meant to reflect the fact that medical collections are less predictive of future credit risk than non-medical collections.[9] The distinction between how medical collections are treated across credit models is likely to be particularly important to individuals with otherwise clean reports.

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[8] For empirical evidence in support of this see Brevoort, K. P., & Kambara, M. (2015). Are all collections equal? The case of medical debt. *Journal of Credit Risk*, *11*(4).
[9] Brevoort and Kambara (2015).

However, many lenders do not use the latest credit models and may even employ their own. Indeed, FICO Score 8, which does not distinguish between medical and non-medical collections, is one of the most common models currently used.[10] Thus, medical collections may still have a direct effect on credit scores for a substantial portion of consumers.

Recent empirical work has helped to clarify how medical debts in collections affect consumers' finances in real-world settings by studying natural experiments which have first-order effects on the prevalence of medical collections. These papers typically investigate settings in which populations experience stark changes in insurance coverage and ask how credit outcomes change afterwards.

For example, several studies have made use of the increase in insurance coverage owing to Medicare eligibility at age 65. These studies show that the drop in uninsurance causes a reduction in the amount of medical collections incurred by consumers.[11] For example, Batty, Gibbs, and Ippolito (2022) show that the mean dollar value of medical collections incurred per year falls by $63, or 56 percent, following Medicare eligibility (figure 3).

Figure 3: Mean dollar value of medical collections, 2013. Reproduced from Batty, Gibbs, and Ippolito (2022)
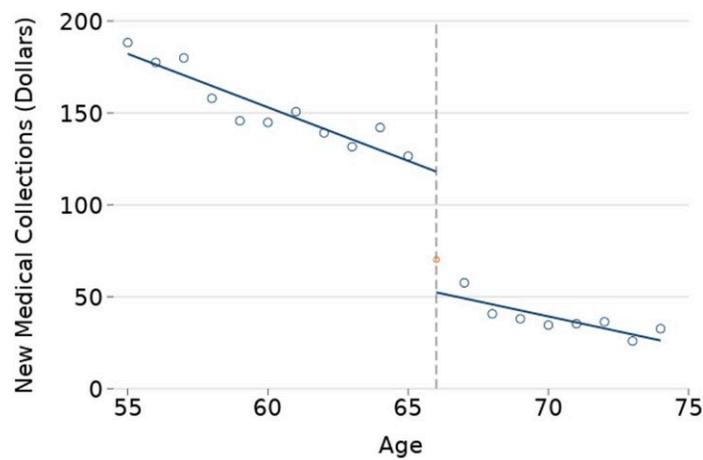
Note: Mean dollar value of medical collections, 2013. RD estimate: -$63***. Figure and regression discontinuity estimate are generated from evaluating Equation (2) linear polynomial in age. We omit consumers who turn 66 in a year when calculating polynomials on either side, but we illustrate the age 66 value in our figures as a red circle. Data are from the CFPB CCP for 2013 (1,279,844 observations). *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

That said, credit data indicate little evidence that these reductions in medical collections trigger broad improvement in other financial outcomes measured on credit reports. Batty, Gibbs, and Ippolito (2022) finds that outcomes not directly tied to health care bills—like credit scores, credit card utilization, the dollar value of non-medical collections, rate at which consumers become more delinquent on debt, public records, or bankruptcy filings—hardly change around the age 65

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[10] https://www.ficoscore.com/education

[11] Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics.* Goldsmith-Pinkham, P., Pinkovskiy, M., & Wallace, J. (2021). The Great Equalizer: Medicare and the Geography of Consumer Financial Strain. Working paper. Caswell, K. J., & Goddeeris, J. H. (2020). Does Medicare reduce medical debt?. *American Journal of Health Economics*, 6(1), 72-103.

threshold (figure 4). These results were similar when looking at areas where one would expect the largest effect sizes (e.g., places where insurance coverage was low at baseline). In other words, the large reduction in the value of medical collections on credit reports does not seem to translate to general improvements in other credit outcomes on average.

These data provide important context for the empirical link between medical collections and other credit outcomes at the population level. Of course, they do not rule out the possibility that individuals or smaller groups of consumers benefit in these circumstances and they cannot speak to outcomes which are not included in credit data.
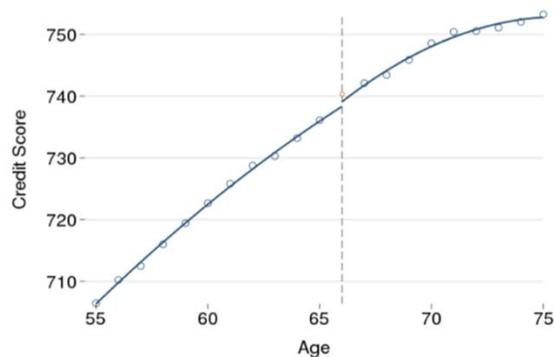
Figure 4: Non-medical collections outcomes, surrounding age 65 Medicare eligibility. Reproduced from Batty, Gibbs, and Ippolito (2022).
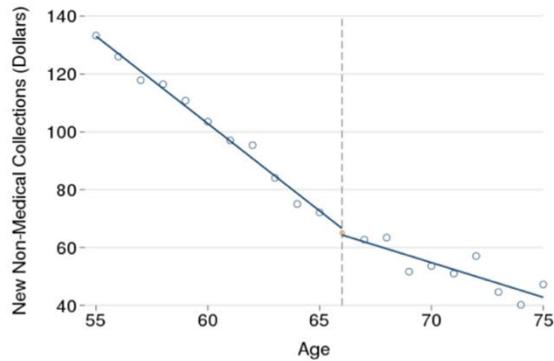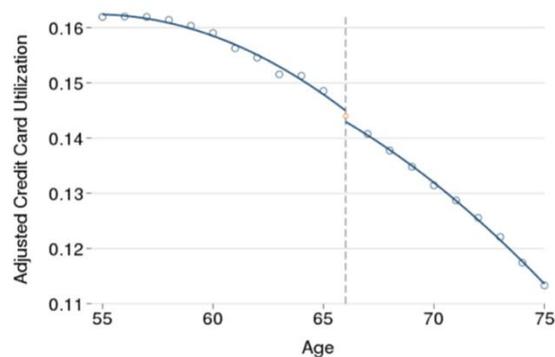

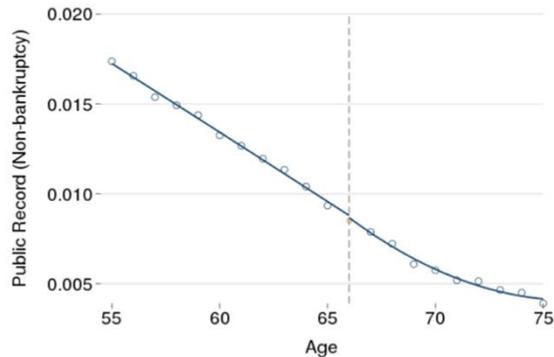**(a)** Unconditional Mean Dollar Value of Non-Medical Collections, 2013. RD Estimate: -$1.01
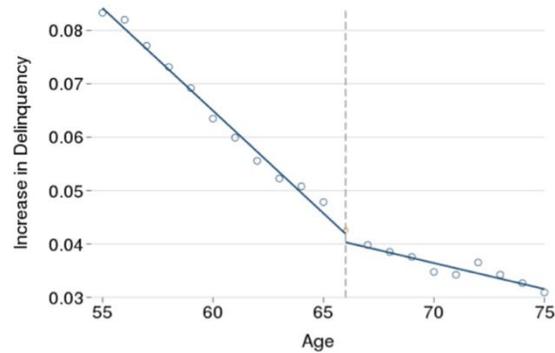
(b) Fraction Becoming More Delinquent on Debt in a Year, 2013. RD Estimate: -0.002

(c) Credit Score, 2013. RD Estimate: 0.42

(d) Credit Card Utilization, 2013. RD Estimate:

(e) Annual Rate of Public Records, 2009-2013. RD Estimate: -0.00007
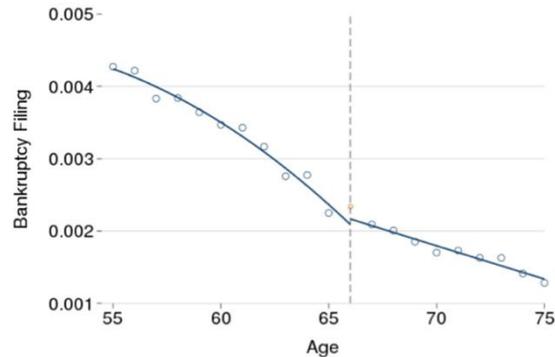
(f) Annual Rate of Bankruptcy Filing, 2009-2013. RD Estimate: 0.00012

Note: This figure shows CFPB CCP outcomes on credit reports that are not directly related to medical care. Delinquencies are any increase in delinquency status conditional on at least 30 days of delinquency on installment or revolving credit accounts. Observations range from 1,182,390 to 5,948,142.

Evidence surrounding the enactment of the Affordable Care Act's (ACA) "under 26" provision reveals broadly similar results.[12] The most compelling real-world evidence that medical debt reductions can spurn broader personal financial improvements comes from Medicaid. Studies show a clear reduction in medical collections following Medicaid expansions[13] and identify improvements to some outcomes like credit scores.[14]

The somewhat inconsistent link between medical collections and other credit outcomes likely reflects multiple factors. Importantly, the context of studies varies. Studies that focus on Medicaid, for example, may be more likely to find broader financial benefits because Medicaid comes with extremely low cost sharing (thus, should mechanically eliminate most bills) and targets those with particularly low incomes. Still, large-scale interventions like Medicare eligibility or the ACA's dependent coverage provision are very useful for understanding these relationships in very large swaths of the population.

Characteristics of medical collections themselves may also play an important role in understanding these results. Conditional on being sent to collections and reported on a credit report, medical bills are rarely repaid. Batty, Gibbs, and Ippolito (2022) show that only about eight percent of medical collections are ever reported as paid on a credit report (figure 5). This repayment rate is also consistent with medical collections representing a relatively low priority form of debt for consumers with competing obligations (a decision that is likely rational given constraints and is often recommended by consumer groups).[15] Rather than remaining on credit records until they must be removed (after seven years) most stop being reported much earlier. The majority are no longer reported within seven months of first appearing on a credit record.

This low repayment rate and relatively short persistence mute one key channel through which reductions in medical collections could trigger broader improvements to personal finances. If consumers were diverting resources to pay these obligations, then their removal would directly free up money for other purposes. If they were relatively unlikely to do that, however, this channel is attenuated.

It is important to note that these data cannot speak to potentially important non-financial consequences of medical debt, including the costs associated with collections activity itself or if patients are reluctant to seek care out of concern for potential debts.

[12] Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics*.

[13] E.g., Miller, S., Hu, L., Kaestner, R., Mazumder, B., & Wong, A. (2021). The ACA Medicaid Expansion in Michigan and financial health. *Journal of Policy Analysis and Management*, *40*(2), 348-375. Brevoort, K., Grodzicki, D., & Hackmann, M. B. (2020). The credit consequences of unpaid medical bills. *Journal of Public Economics*, *187*, 104203. Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J. P., Allen, H., Baicker, K., & Oregon Health Study Group. (2012). The Oregon health insurance experiment: evidence from the first year. *The Quarterly journal of economics*, *127*(3), 1057-1106.

[14] E.g., Brevoort, K., Grodzicki, D., & Hackmann, M. B. (2020).

[15] *Dealing with medical debt: Consumer advice from NCLC*. Dealing with Medical Debt: Consumer Advice from NCLC | NCLC Digital Library. (2018, May 17). Retrieved March 23, 2022, from https://library.nclc.org/dealing-medical-debt-consumer-advice-nclc

Figure 5: Persistence of medical collections on credit reports. Reproduced from Batty, Gibbs, and Ippolito (2022).
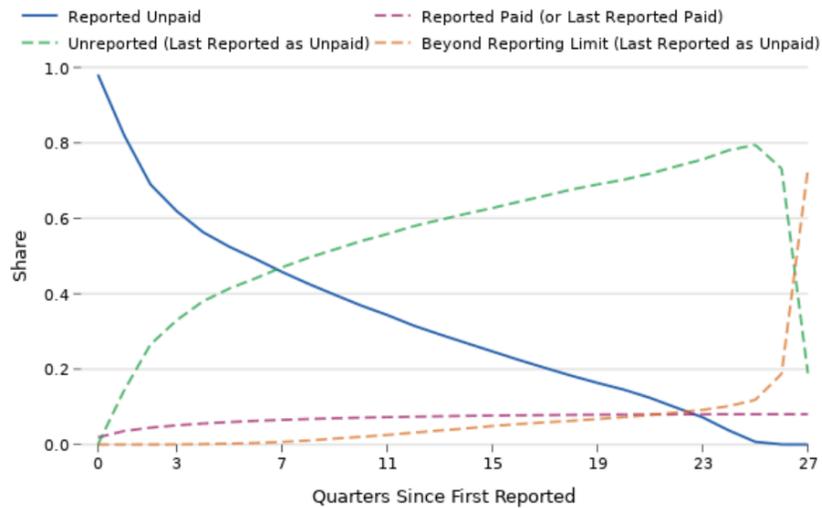
Note: This figure shows the status of medical debt in collections that was incurred in 2011 through the first half of 2013 by quarter since it was first reported on a consumer's credit record in the CFPB CCP. The solid blue line represents the share of those medical collections that are still reported as unpaid. This share falls over time as bills are reported as paid (purple dashed line), they reach the seven year reporting threshold (orange dashed line), or they have not been paid but are no longer reported to the consumer reporting agency for other reasons (green dashed line).

Implications for potential and forthcoming policy changes

There are a host of policy changes that could affect the prevalence of medical debt or its influence on household finances. In this section, I consider a non-exhaustive list and emphasize potential tradeoffs that policymakers should consider.

Addressing underlying causes of medical debt

At a mechanical level, polices that aim to reduce the amount of unpaid medical bills must either reduce health care bills or increase the rate at which consumers' pay them. The suite of policies to do that is, of course, very broad. Health care reforms that reduce health care costs, expand insurance, or simplify health care billing processes, would typically lower the rate of medical debt. This is also true of policies that aim to reduce the prevalence of unexpected bills that might give rise to the most unavoidable sources of medical debt, like the No Surprises Act.

A full consideration of the merits of policy changes along these lines is beyond the scope of this testimony, but I will emphasize a few conceptual points. Efforts to lower health costs come with inevitable tradeoffs. Even if health markets exhibit some level of inefficiency, expenditures rarely purchase nothing of value. Policies should aim to balance the benefit to consumers stemming from lower health costs with general equilibrium effects on other outcomes, like quality of care. As a general rule, policies that lower health costs by targeting sources of inefficient spending—like reducing consolidation incentives, eliminating open-ended subsidies that contribute to price insensitivity, and so on—are likely to increase welfare the most.

It is also important to understand that the incidence of unpaid medical bills does not fall entirely on consumers, but also on health care providers.[16] Thus, much of the value of policies that increase payment of bills (e.g., increasing insurance coverage or lowering cost sharing) will be borne by health care providers. Policymakers should weigh these transfers in light of others that already exist to partly compensate for this lack of payment (e.g., Disproportionate Share Hospital payments).

The suite of policies that would affect consumers' personal finances in advance of receiving health care bills is perhaps even broader, involving tax policy, unemployment insurance, productivity growth, and much more.

Increasing the accuracy of medial collections included on credit reports
The purpose of credit modeling is to provide information about credit worthiness of potential borrowers. If some medical collections on reports are inaccurate or likely convey no meaningful information about credit risk, there is an argument for changing how these debts are reported.

There are at least two settings in which medical collections are likely to convey relatively little information about credit worthiness. First, consider bills that initially go unpaid as a result of a consumer's confusion over billing practices, but that are later paid. The lack of payment in these cases may not fully reflect credit risk. Policies that allow lenders to distinguish these types of collections should improve signals of credit worthiness. In addition, if bills are regularly being reported on credit reports before potential uncertainty over payment is resolved, one could justify further delaying their appearance on credit records as a way to accomplish similar goals.

Recent changes announced by the major credit bureaus would enact changes along these lines.[17] Specifically, they would require that unpaid medical collections not appear on credit reports for at least a year (up from the current standard of six months from date of first delinquency). In addition, they would remove medical collections that have been paid. Although one could argue in favor of simply identifying collections that have been paid (as some newer credit models do), these changes generally work towards the appropriate goal of improving signals about credit risk.

Restricting reporting of accurate unpaid medical collections
There are other proposals that would seek to limit the ability to observe medical collections even if they likely represent valid bills. This includes the recently-announced decision by the main credit bureaus to suppress medical collections that are under $500 beginning in 2023. Policymakers should consider how lenders might respond to such a change and whether that would meaningfully affect the desired goals.

Medical collections may be less predictive of future repayment risk than other collections, but that does not imply they contain no predictive value. Indeed, the predictive power of medical collections is likely to be higher in a setting where other policies have reduced the noise associated with this flag (i.e., policies mentioned above that reduce the presence of medical collections which are likely to convey little value about credit worthiness). Moreover, it is notable that many lenders still use models which place meaningful weight on medical collections. That fact is consistent with the theory

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[16] Garthwaite, C., Gross, T., & Notowidigdo, M. J. (2018). Hospitals as insurers of last resort. *American Economic Journal: Applied Economics*, *10*(1), 1-39.

[17] Andriotis, A. March 18, 2022. Most Medical Debts to Be Removed From Consumers' Credit Reports. *Wall Street Journal.*

that they view those debts as informative. Thus, disallowing the reporting of this debt does not eliminate the perceived source of risk, but rather, obscures it. There are a few ways lenders might respond in this setting.

First, if lenders believe medical collections held predictive power over future repayment, they may seek to place more emphasis on other entries on credit reports that they believe carry similar information. For example, one might place higher weight on non-medical collections or other delinquencies, raising the cost of borrowing for consumers with those flags on their credit reports. It is not immediately obvious that raising the cost of borrowing for consumers with these flags would have preferable distributional consequences than the status quo (of course, if an alternative flag was highly correlated with medical collections, then similar consumers would be impacted).

If lenders do not think that they can proxy for the obscured source of risk they may consider alternative responses. One option would be to raise the cost of borrowing relatively evenly across all consumers. This would essentially represent a financial transfer from consumers without medical collections to those with them. Another alternative would be to adjust lending behavior in populations where risk is perceived to be high and unobservable. For example, consider younger adults who have some of the highest rates of medical collections on credit reports and are often building credit (thus have thinner files). If lenders believe there is a significant risk that is concentrated in this population, and it is not feasible for them to model it, they may view this group as a generally higher credit risk and be more reluctant to loan to them.

It is important to note that these types of regulatory redistribution efforts are not without precedent. Within health care markets policymakers have often intentionally distorted price signals in an effort to achieve certain kinds of cross subsidization. For instance, regulations often limit how much health insurance premiums can vary with expected health costs of individuals. This is motivated by equity concerns and the inherently unexpected nature of many illnesses and health care utilization. But these efforts have triggered responses by insurers who must price products in the face of imperfectly observable risk. This can destabilize markets for insurance as insurers seek to avoid higher risk enrollees (e.g., this can contribute to "death spiral" type incentives). While distinct from the policy setting under consideration here, this illustrates the kind of dynamic responses policymakers should be attentive to when considering this type of policy change.

Finally, policymakers should be cognizant of potential feedbacks to the provision of health care. By design, eliminating unpaid medical collections from consumer credit profiles reduces the costs of unpaid bills to consumers. Mechanically, this also reduces the incentives for consumers to pay such bills, particularly in cases where they are unlikely to visit the same provider multiple times. If this incentive is salient to consumers, it has the potential to affect rates of payment and alter providers' willingness to treat patients who are perceived to be of higher non-payment risk. Access to health care is a first-order element of consumer wellbeing in this market. Efforts to reduce medical debts are, in part, motivated by concerns that medical debts, themselves, may dissuade consumers from seeking care in the first place. Thus, this margin is worth particular attention as policymakers seek ways to address medical debts.