

National Health Statistics Reports

Number 180 ■ January 18, 2023

Problems Paying Medical Bills: United States, 2021

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Abstract

Objectives—This report presents national estimates of people living in families having problems paying medical bills by selected sociodemographic and geographic characteristics, including sex, race and Hispanic origin, family income, health insurance coverage status, education level, urbanization level, region, and state Medicaid expansion status.

Methods—Data from the 2019, 2020, and 2021 National Health Interview Survey (NHIS) were used to estimate short-term trends in problems paying medical bills in the past 12 months. Data from the 2021 NHIS were used to describe estimates of people who were in families who have problems paying medical bills by selected sociodemographic and geographic characteristics.

Results—Overall, the percentage of people who were in families having problems paying medical bills in the past 12 months decreased from 14.0% in 2019 to 10.8% in 2021. In 2021, males (9.7%) were less likely than females (11.8%) to have problems paying medical bills. The percentage of people who were in families having problems paying medical bills was higher among children aged 0–17 years (11.5%) and adults aged 18–64 (11.3%) than adults aged 65 and over (7.7%). Among people under age 65 and those aged 65 and over, the percentage who were in families having problems paying medical bills varied by health insurance coverage status, family income, and state Medicaid expansion status.

Keywords: financial burden • medical debt • National Health Interview Survey

Introduction

Previously published data from the National Health Interview Survey (NHIS) found that in 2018 about 14% of people were in families that had problems paying medical bills in the past 12 months (1). This was a significant trend downwards from 2011, when nearly 20% of people were in families having problems paying

medical bills (1). More recently, estimates from the Health Reform Monitoring Survey found that problems paying medical bills among adults aged 18–64 decreased from 23.6% in March 2019 to 16.8% in April 2021 (2).

Financial stability has been associated with one's ability to pay medical expenses (3,4). Significant expenses for one family member may adversely affect the whole

family financially (5). People who have medical debt may pay off these bills by taking on other forms of debt, including credit cards and bank loans, or negotiate payment plans with healthcare providers, or just fail to pay them (6–8). However, medical debt continues to be the major form of debt in the United States (9). People who are in families with problems paying medical bills or have medical debt may experience serious financial consequences, such as having problems paying for food, clothing, or housing (rent, mortgage, or utilities), and filing for bankruptcy (3,6,8,10,11). In addition, adults with medical debt are more likely to forgo needed health care due to cost (12).

The inability to pay medical bills and accrued medical expenses can leave families in financial struggle and debt, especially in families with low or moderate incomes. For example, previous findings from NHIS indicated that adults under age 65 who were living with incomes at or near the federal poverty level (FPL) were over three times as likely to have medical bills that they were unable to pay at all compared with those with incomes at or above 200% FPL (4). Health insurance coverage status (that is, uninsured, public coverage, or private coverage) may also impact the ability to afford healthcare costs (1,13). Among people under age 65, those who



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were uninsured were more likely than those with Medicaid or private coverage to be in families having problems paying medical bills (1). Among older adults, the percentages of those who were in families having problems paying medical bills were higher among those with Medicare and Medicaid and Medicare-only coverage than those with Medicare Advantage or private coverage (1).

A recent study found that adults aged 19–64 who were impacted by the COVID-19 pandemic due to illness or testing positive, decreased income, or loss of job-based healthcare coverage were more likely to have higher rates of medical bills and debt problems than adults aged 19–64 who had not experienced these three pandemic effects (6). However, another study using county-level data from 2018 to 2020 found no significant association between medical debt and the COVID-19 pandemic across counties with different income levels and pandemic severity (14).

This report presents estimates of the percentage of people who are in families having problems paying medical bills in the past 12 months. Short-term trends from 2019 through 2021 in problems paying medical bills are shown by age group in [Table 1](#). To understand current sociodemographic differences in problems paying medical bills, estimates for 2021 are also presented by age group and selected sociodemographic and geographic characteristics, including sex, race and Hispanic origin, family income, health insurance coverage, family education level, urbanization level, region, and state Medicaid expansion status in [Table 2](#). Selected highlights from these tables are presented in the Results section of this report.

Methods

Data source

The estimates in this report are based on data from the Sample Adult and Sample Child modules of the 2019–2021 NHIS. NHIS is a nationally representative household survey of the U.S. civilian noninstitutionalized population. It is conducted continuously throughout the year by the National Center for Health Statistics (NCHS).

From each household, one sample adult is randomly selected to answer detailed questions about their health. One sample child, if present, is also randomly selected from each household, and an adult who is knowledgeable and responsible for the child's health answers questions on the child's behalf. Interviews are typically conducted in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone when necessary.

Impact of the COVID-19 pandemic on data collection

Due to the COVID-19 pandemic, NHIS data collection shifted from in-person interviews in the home to a telephone-only mode beginning on March 19, 2020 (15). Personal visits to households resumed in selected areas in July 2020 and in all areas of the country in September 2020. However, cases were still attempted by telephone first, and most were completed by telephone. For more information about the impact of these changes on the 2020 data and general information about NHIS, visit <https://www.cdc.gov/nchs/nhis/2020nhis.htm>.

In 2021, due to ongoing data collection difficulties posed by the COVID-19 pandemic, NHIS cases continued to be attempted by telephone first from January to April 2021 (16). Personal visits were used only to followup on nonresponse, deliver recruitment materials, and conduct interviews when telephone numbers were unknown. Starting in May 2021, interviewers were instructed to return to regular survey interviewing procedures, whereby first contact attempts to households were made in person, with follow-up allowed by telephone. Interviewers were given flexibility to continue using telephone-first contact attempts based on local COVID-19 conditions.

Problems paying medical bills

Problems paying medical bills is a family-level measure that may be collected as part of the Sample Adult interview or as part of the Sample Child

interview or both, depending upon the circumstance (16). The respondent is asked, "In the past 12 months, did you or anyone in the 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." When the sample adult and sample child belong to the same family, the question is asked only during the first interview. This helps to minimize respondent burden by eliminating repetition. In turn, the data are replicated during data processing. When the sample adult and sample child are in different families within the same household, both respondents will be asked the family-level questions about their respective families. Therefore, to study problems paying medical bills, the Sample Adult and Sample Child files can be combined to create a file that contains people of all ages.

Sample sizes and response rates

For 2019, estimates were based on a combined file containing 42,331 people (9,193 sample children and 33,138 sample adults). For 2020, estimates were based on a combined file containing 37,358 people (5,790 sample children and 31,568 sample adults). For 2021, estimates were based on a combined file containing 37,743 people (8,261 sample children and 29,482 sample adults). The 2019 response rate for the Sample Adult module was 59.1% and for the Sample Child module was 59.1% (17). The 2020 NHIS Sample Adult (excluding reinterviewed Sample Adults) and Sample Child response rates were 48.9% and 47.8%, respectively (15). For 2021 NHIS, Sample Adult and Sample Child response rates were 50.9% and 49.9%, respectively (15).

Selected sociodemographic and geographic characteristics

Family education level—Based on years of school completed or the highest degree obtained among all adults within a family. The high school diploma category includes those who obtained a GED.

Family income—Based on the ratio of the family's income in the previous calendar year to the appropriate threshold (given the family's size and number of children) defined by the U.S. Census Bureau (18). People were classified into four groups based on their family income: less than 100% FPL, 100% to less than 200% FPL, 200% to less than or equal to 400% FPL, and greater than 400% FPL. Family income in NHIS was imputed for about 22% of people (19).

Health insurance coverage—Collected at the time of interview. Sample adults and sample child respondents reported whether they or the sample child were covered by private insurance, Medicare (including Medicare Advantage plans), Medigap (supplemental Medicare coverage), Medicaid, Children's Health Insurance Program (CHIP), Indian Health Service (IHS), military coverage (including VA, TRICARE, or CHAMP-VA), a state-sponsored health plan, or another government program.

For people under age 65, a health insurance hierarchy of four mutually exclusive categories was used (20). People with more than one type of health insurance were assigned to the first appropriate category in the following hierarchy: private, Medicaid and CHIP, other coverage, and uninsured.

For adults aged 65 and over, a health insurance hierarchy of six mutually exclusive categories was developed. This hierarchy eliminates duplicate responses for both private health insurance and Medicare Advantage, giving preference to the report of Medicare Advantage. Medicare Advantage is another way for people covered by Medicare to get their Medicare Part A and Medicare Part B coverage. Medicare Advantage plans are sometimes called "Part C" and are offered by Medicare-approved companies that must follow rules set by Medicare (21). Older adults with more than one type of health insurance were assigned to the first appropriate category in the following hierarchy: private, Medicare and Medicaid (dual-eligible), Medicare Advantage, traditional Medicare only, other coverage, and uninsured (22).

Race and Hispanic origin—Based on responses to two questions that determine Hispanic or Latino origin and race.

People categorized as Hispanic may be of any race or combination of races. People categorized as non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, and non-Hispanic American Indian or Alaska Native indicated one race only. Non-Hispanic people of multiple or other races (includes those who did not identify as White, Black, Asian, American Indian or Alaska Native, or Hispanic, or who identified as more than one race) are combined into the non-Hispanic other and multiple races category.

Region—Based on four regions used by the U.S. Census Bureau. Northeast includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. Midwest includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. West includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

State Medicaid expansion status—Under provisions of the Affordable Care Act of 2010 (23), states have the option to expand Medicaid eligibility to cover adults who have family incomes up to and including 138% of FPL. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2021, 36 states and the District of Columbia had expanded Medicaid. Medicaid expansion states include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also has expanded Medicaid. States without expanded Medicaid include Alabama,

Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Urbanization level—Categorized by collapsing the "2013 NCHS Urban–Rural Classification Scheme for Counties" (24,25). The NCHS urban–rural classification is based on metropolitan statistical area (MSA) status defined by the Office of Management and Budget according to published standards that are applied to U.S. Census Bureau data.

This report condenses the NCHS urban–rural classification into four categories: large central metropolitan (similar to inner cities), large fringe metropolitan (similar to suburbs), medium and small metropolitan, and nonmetropolitan (25,26). Large metropolitan areas have populations of 1 million or more. Metropolitan areas with populations of less than 1 million were classified as medium (250,000–999,999 population) or small (less than 250,000 population) (25).

Statistical analysis

Percentages are presented for prevalence estimates of problems paying medical bills, and 95% confidence intervals (CI) were generated using the Korn–Graubard method for complex surveys (27). Estimates were calculated using the NHIS survey weights and are representative of the U.S. civilian noninstitutionalized population. The weighting adjustment method incorporates robust multilevel models predictive of response propensity. Nonresponse-adjusted weights were further calibrated to U.S. Census Bureau population projections and American Community Survey (ACS) 1-year estimates for age, sex, race and ethnicity, education level, housing tenure, census division, and MSA status (15,17). For the 2021 survey year, the U.S. Census Bureau did not release single-year ACS estimates by housing tenure, education level, and MSA by division. Therefore, substitute calibration totals for these variables were obtained from the 2021 Current Population Survey March Annual Social and Economic Supplement (16).

Point estimates and their corresponding variances were calculated using SUDAAN software version

11.0.0, a software package designed to account for the complex sampling design of NHIS. Respondents with missing data or unknown information were generally excluded from the analysis unless specifically noted. All estimates presented in this report met NCHS standards of reliability as specified in “National Center for Health Statistics Data Presentation Standards for Proportions” (28).

Differences in percentages between subgroup characteristics were evaluated using two-sided significance tests at the 0.05 level. Trends by family income (as a percentage of FPL), education level, and urbanization level were evaluated using orthogonal polynomials in logistic regression. Terms such as “more likely” and “less likely” indicate a statistically significant difference. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and not found to be significant.

Results

Trends from 2019 through 2021

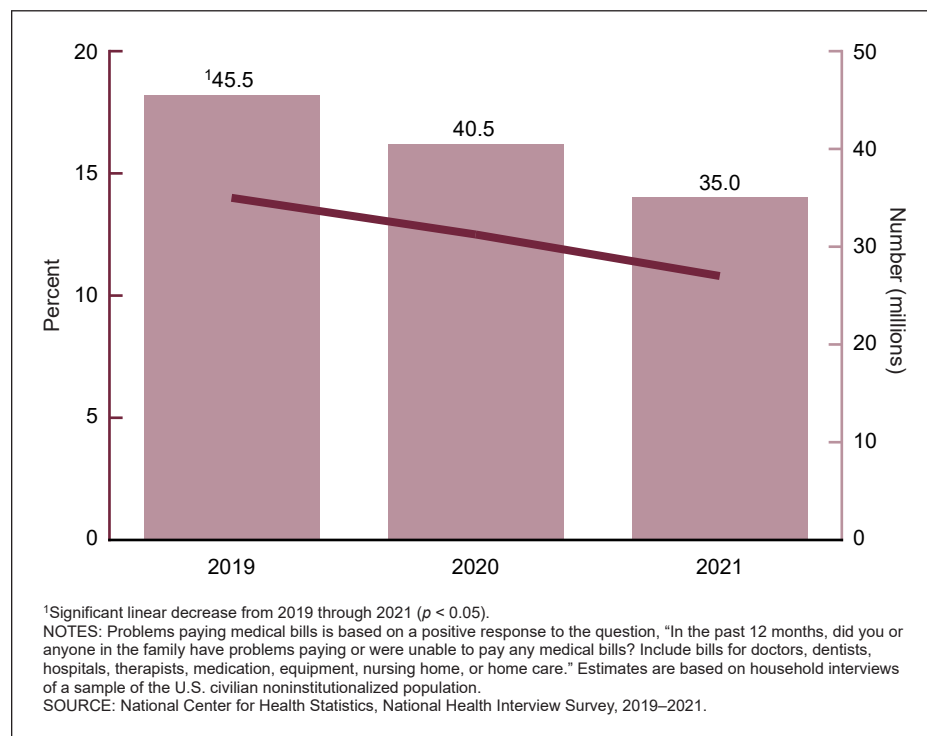
Overall, the percentage of people who were in families having problems paying medical bills in the past 12 months decreased 3.2 percentage points from 2019 (14.0%) to 2021 (10.8%) (Figure 1, Table 1). In 2021, 10.5 million fewer people (35.0 million) were in families having problems paying medical bills than in 2019 (45.5 million).

Selected sociodemographic results for 2021

Sex, age group, and race and Hispanic origin

In 2021, among people of all ages, females (11.8%) were more likely than males (9.7%) to be in families having problems paying medical bills in the past 12 months (Figure 2, Table 2). The percentage of people who were in families having problems paying medical bills was higher among children aged 0–17 years (11.5%) and adults aged 18–64 (11.3%) than adults aged 65 and over (7.7%).

Figure 1. Percentage and number of people of all ages who were in families having problems paying medical bills in the past 12 months, by year: United States, 2019–2021



The percentage of people who were in families having problems paying medical bills was higher among non-Hispanic Black people (15.8%) compared with Hispanic (12.8%), non-Hispanic White (9.4%), and non-Hispanic Asian (6.1%) people. Estimates for people who are non-Hispanic American Indian or Alaska Native (11.5%) and non-Hispanic other and multiple races (15.1%) were not significantly different from estimates for non-Hispanic Black people (15.8%). Non-Hispanic Asian people were less likely than all other race and ethnicity groups to be in families having problems paying medical bills.

Health insurance

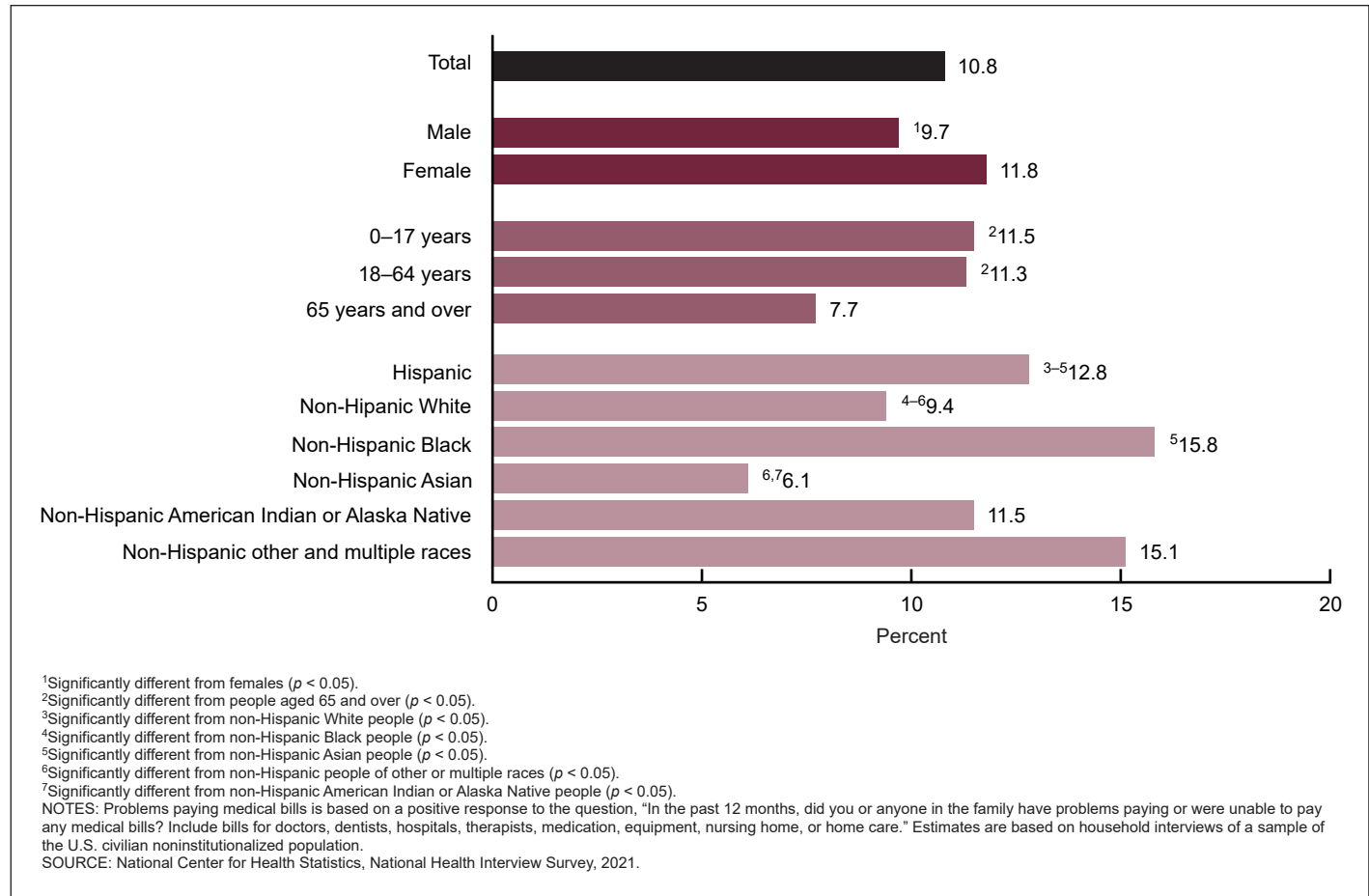
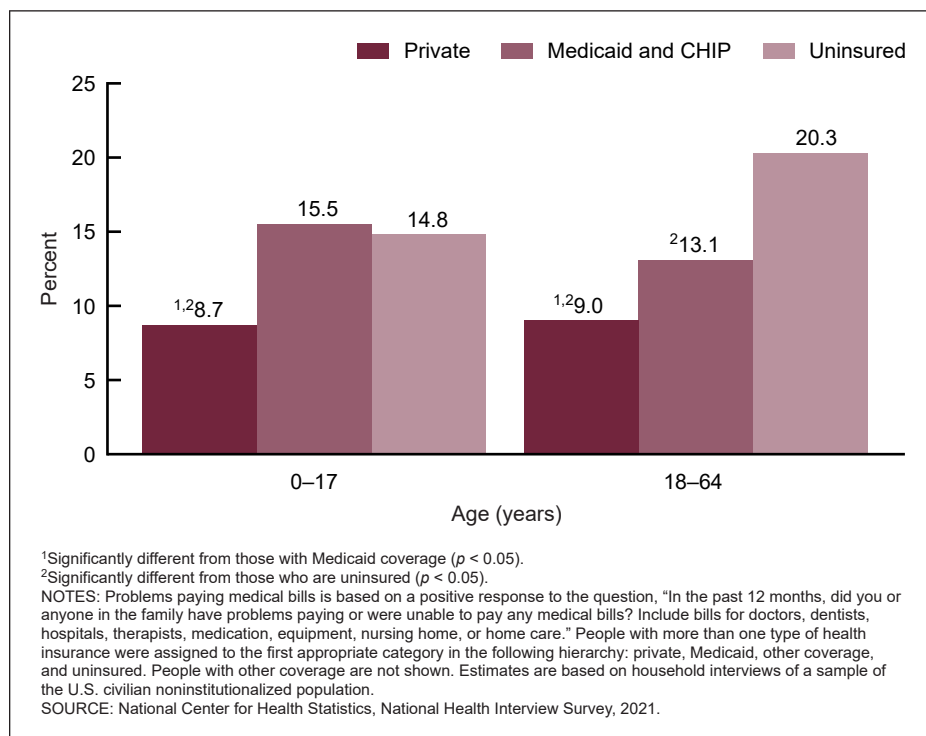
In 2021, among children aged 0–17 years, those with Medicaid and CHIP coverage (15.5%) were as likely as those who were uninsured (14.8%) to be in families having problems paying medical bills in the past 12 months (Figure 3, Table 2). Children with Medicaid and CHIP coverage or those who were uninsured were more likely than children with private coverage (8.7%) to be in families having problems paying medical bills. Among adults aged 18–64, 20.3% of those who were uninsured, followed

by 13.1% of those with Medicaid and CHIP and 9.0% of those with private coverage were in families having problems paying medical bills.

In 2021, among adults aged 65 and over, those with private coverage (4.8%) were less likely than those with Medicare and Medicaid (11.3%), Medicare Advantage (8.9%), traditional Medicare only (9.8%), and other coverage (9.1%) to be in families having problems paying medical bills (Figure 4). No significant differences were observed among older adults with Medicare and Medicaid, Medicare Advantage, traditional Medicare only, and other coverage.

Family income

In 2021, among people under age 65, the percentage who were in families having problems paying medical bills in the past 12 months decreased from those with family incomes less than 100% FPL (17.6%) and incomes 100% to less than 200% FPL (18.8%) to those with family incomes 200% to less than or equal to 400% FPL (13.7%) to those with incomes greater than 400% FPL (4.5%) (Figure 5, Table 2). Among adults aged 65 and over, a decreasing trend in problems paying medical bills was

Figure 2. Percentage of people who were in families having problems paying medical bills in the past 12 months, by sex, age group, and race and Hispanic origin: United States, 2021**Figure 3. Percentage of people under age 65 who were in families having problems paying medical bills in the past 12 months, by age group and health insurance status: United States, 2021**

observed with increasing levels of income, from 15.5% among those with family incomes less than 100% FPL to 2.8% among those with family incomes greater than 400% FPL.

State Medicaid expansion status

In 2021, people living in Medicaid expansion states (9.3%) were less likely than those living in states that did not expand Medicaid (13.5%) to be in families having problems paying medical bills in the past 12 months (Figure 6, Table 2). Significant differences in the percentage with problems paying medical bills between Medicaid expansion states and nonexpansion states were observed for children aged 0–17 years (9.9% compared with 14.7%), adults aged 18–64 (9.8% compared with 14.4%), and adults aged 65 and over (7.0% compared with 9.0%).

Figure 4. Percentage of adults aged 65 and over who were in families having problems paying medical bills in the past 12 months, by health insurance status: United States, 2021

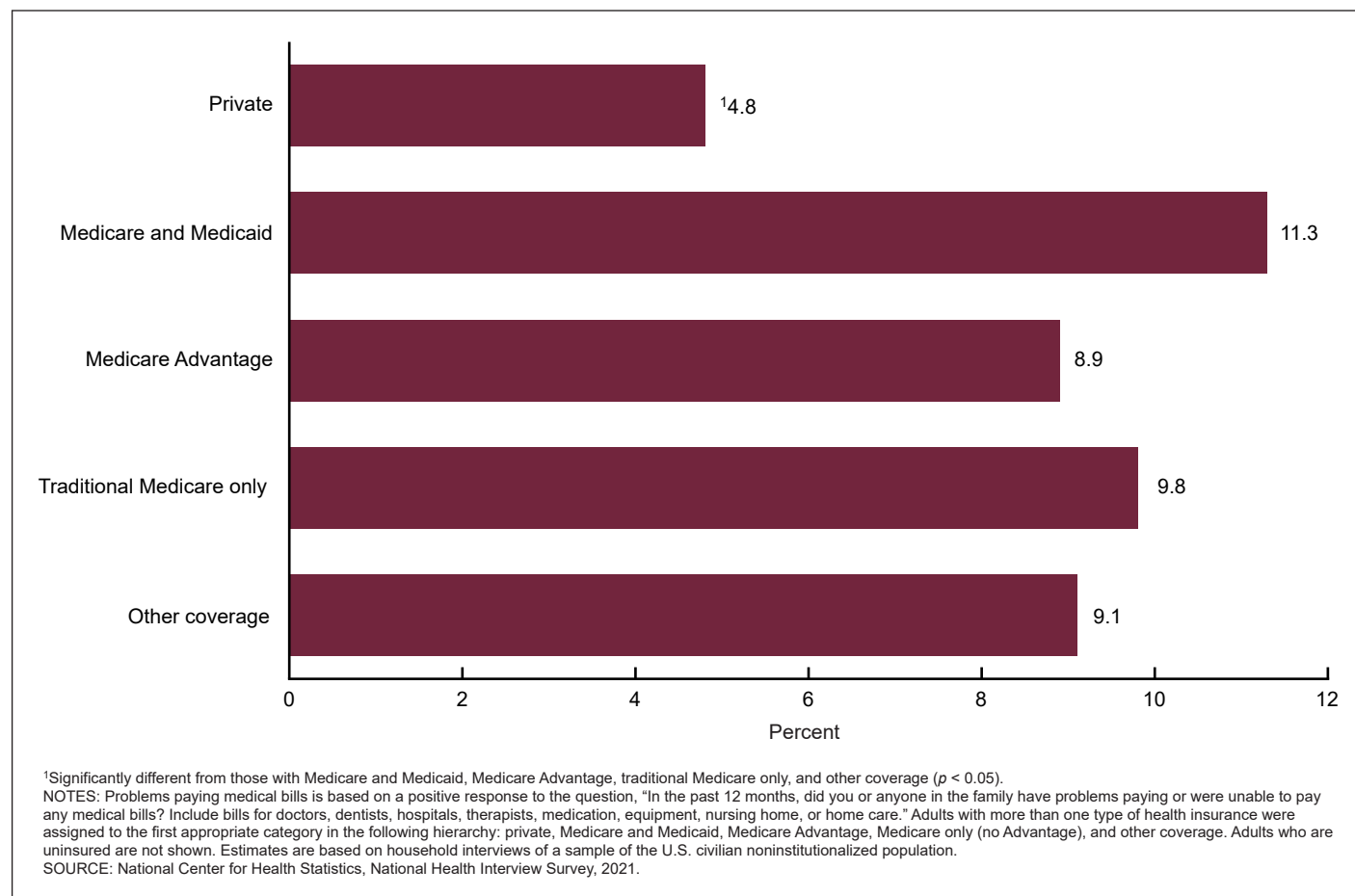
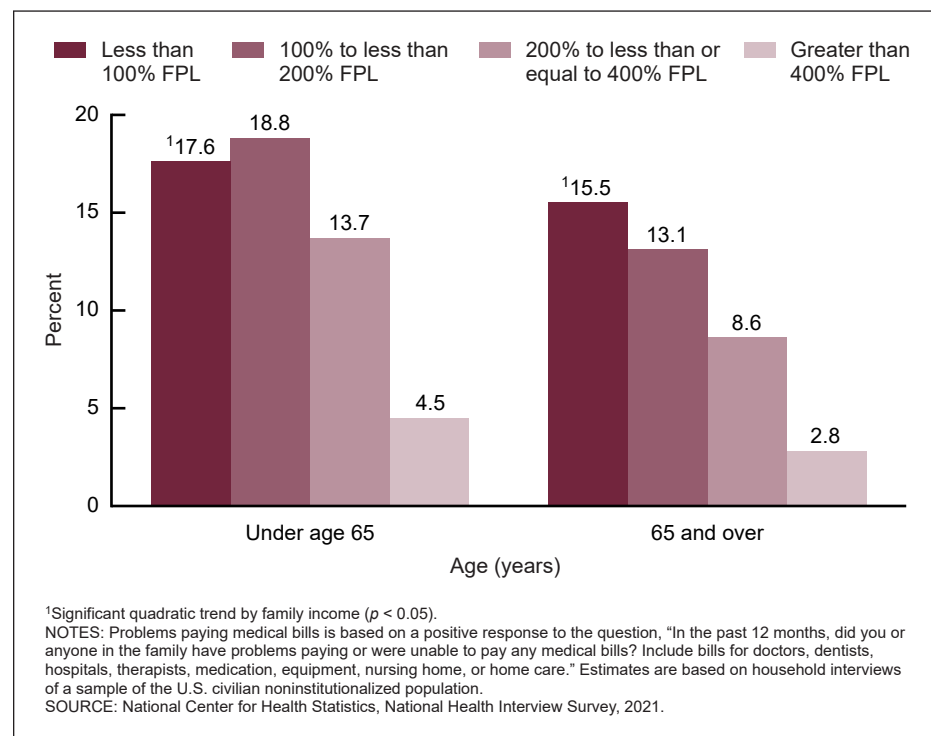


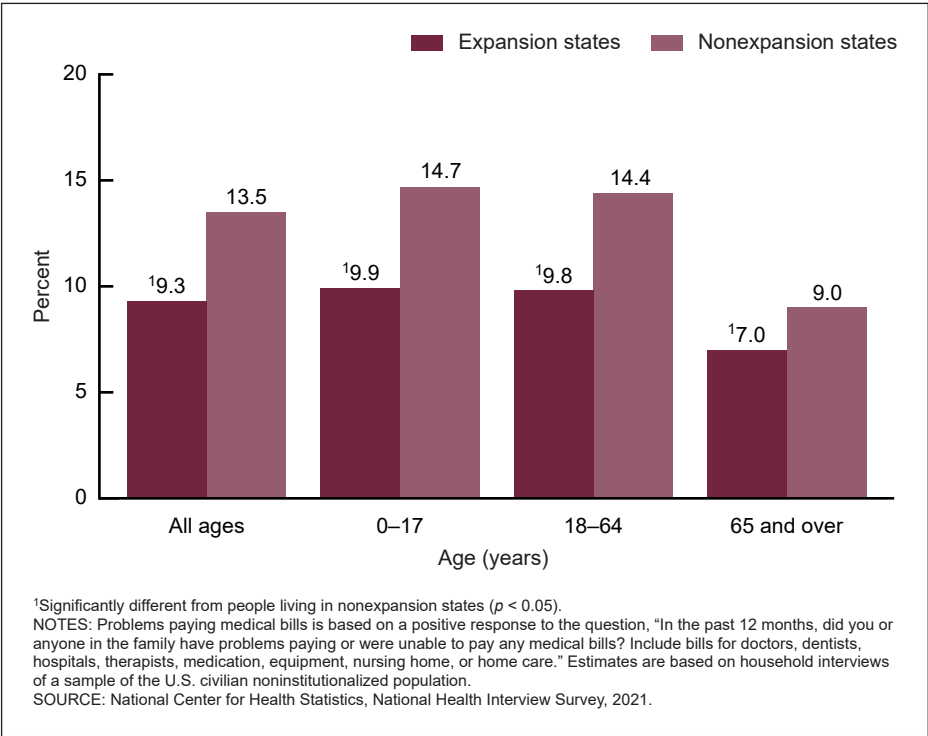
Figure 5. Percentage of people who were in families having problems paying medical bills in the past 12 months, by age group and family income as a percentage of the federal poverty level: United States, 2021



Discussion

In 2021, the percentage of people who were in families having problems paying medical bills in the past 12 months decreased 3.2 percentage points from 14.0% in 2019 to 10.8% in 2021. This corresponded to 10.5 million fewer people who were in families having problems paying medical bills in 2021 (35.0 million) than in 2019 (45.5 million). Similar decreases in problems paying medical bills during the COVID-19 pandemic were reported by Karpman et al (2). The decrease observed over this 3-year period may be a continuation of decreasing trends from 2011 that were previously reported (1). However, a direct comparison between 2019 and later years and years before 2019 should be made with caution due to a 2019 redesigned questionnaire and changes in weighting and design methodology (17). The impact of these changes has not been fully evaluated at this time.

Figure 6. Percentage of people who were in families having problems paying medical bills in the past 12 months, by age group and state Medicaid expansion status: United States, 2021



However, the impact of the COVID-19 pandemic on problems paying medical bills cannot be discounted. Provisions as part of the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act (29), The Consolidated Appropriations Act, 2021 (30), and The American Rescue Plan Act of 2021 (31) may have helped indirectly to mitigate the impact of the pandemic on people having problems paying medical bills. This legislation provided direct monetary payments, flexibility with payments to creditors, additional unemployment assistance, subsidized payroll for affected small businesses, and improvements in paid sick leave (32). Additionally, the American Rescue Plan Act of 2021 may have helped mitigate the impact of the pandemic on problems paying medical bills by increasing the percentage of people covered by insurance (33) using COBRA premium subsidies, removing the income limit for subsidy eligibility for those purchasing private plans through the Marketplaces, and increasing subsidies already available to those with lower incomes (34). This law also made changes to the Medicaid program designed to increase coverage and expand benefits (35). This may be supported in part in that people living

in Medicaid expansion states were less likely than those living in nonexpansion states to have problems paying medical bills for all age groups including adults aged 65 and over. In addition, during the early months of the pandemic, a decrease was observed in the use of preventive and elective medical care (36,37), outpatient visits (38), and hospital emergency department visits (39), which may also have reduced the potential for medical debt through fewer copays, deductibles, and coinsurance, and may be reflected in the estimates shown in this report.

This report also provides a more detailed picture of problems paying medical bills in the United States by selected sociodemographic and geographic characteristics for 2021. Estimates varied by sex, age, race and Hispanic origin, health insurance coverage status, family income, and state Medicaid expansion status. People were more likely to have problems paying medical bills if they had low family income, were uninsured, or resided in non-Medicaid expansion states. These sociodemographic differences were similar to those reported previously (1,7). People who are in families with problems paying medical bills not only face financial consequences (3,8,10,11),

but also may forgo medical care and prescription drugs (12,40). Despite the decreasing trend in the percentage of people with problems paying medical bills, the burden associated with unpaid medical bills remains a public health concern.

One strength of NHIS is that it has a low item nonresponse rate on the questions about problems paying medical bills (less than 1%). In addition, problems paying medical bills can be analyzed in combination with other measures available on NHIS, including forgone care, worry about healthcare costs, healthcare access and use, chronic conditions, and health behaviors. However, NHIS responses are self-reported and so, they may be subject to recall bias. Additionally, although respondents are asked to confine their responses to those family members that they live with, they may have either thought only about their own difficulty with paying for medical care or may have thought about medical care they are paying for on behalf of a member not living in their household, such as a parent living in a long-term care facility.

Medical debt is a major contributor to overall debt in the United States (9). Monitoring problems paying medical bills continues to be an important measure for assessing the financial burden of medical care and medical debt as rising healthcare costs are a dominant concern in the United States (7). NHIS continues to be a national resource for monitoring financial burden for medical care in the United States.

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Table 1. Percentage and number of people who were in families having problems paying medical bills in the past 12 months, by year and age group: United States, 2019–2021

Age group (years)	2019	2020	2021
Percent (95% confidence interval)			
All ages.	14.0 (13.5–14.6)	12.5 (11.9–13.1)	10.8 (10.3–11.2)
Under 65.	14.9 (14.3–15.6)	13.3 (12.6–14.0)	11.4 (10.9–11.9)
0–17.	15.0 (14.1–15.9)	13.7 (12.5–15.0)	11.5 (10.7–12.4)
18–64.	14.9 (14.3–15.6)	13.1 (12.5–13.8)	11.3 (10.8–11.9)
65 and over.	9.4 (8.6–10.3)	8.4 (7.7–9.2)	7.7 (7.0–8.5)
Number (millions)			
All ages.	45.5	40.5	35.0
Under 65.	40.5	35.9	30.7
0–17.	11.0	10.0	8.3
18–64.	29.5	25.9	22.3
65 and over.	5.0	4.6	4.3

NOTES: Problems paying medical bills is based on a positive response to the question, "In the past 12 months, did you or anyone in the 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." Estimates may not add up to the total number in millions due to rounding. Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019–2021.

Table 2. Percentage of people who were in families having problems paying medical bills in the past 12 months, by age group and selected characteristics: United States, 2021

Selected characteristic	Age group (years)				
	All ages	Under 65	0–17	18–64	65 and over
Percent (95% confidence interval)					
Total	10.8 (10.3–11.2)	11.4 (10.9–11.9)	11.5 (10.7–12.4)	11.3 (10.8–11.9)	7.7 (7.0–8.5)
Sex					
Male	9.7 (9.1–10.3)	10.3 (9.6–10.9)	11.7 (10.6–13.0)	9.7 (9.1–10.4)	6.7 (5.7–7.8)
Female	11.8 (11.1–12.4)	12.5 (11.8–13.2)	11.3 (10.2–12.6)	12.9 (12.1–13.7)	8.6 (7.5–9.7)
Race and Hispanic origin ¹					
Hispanic	12.8 (11.6–14.1)	12.8 (11.5–14.1)	12.6 (10.9–14.4)	12.8 (11.5–14.3)	13.1 (9.6–17.2)
Non-Hispanic White	9.4 (8.8–9.9)	10.2 (9.5–10.9)	10.2 (9.1–11.4)	10.2 (9.5–10.8)	6.4 (5.7–7.1)
Non-Hispanic Black	15.8 (14.2–17.5)	16.1 (14.4–18.0)	14.8 (12.0–17.9)	16.6 (14.8–18.6)	13.7 (10.9–17.0)
Non-Hispanic Asian	6.1 (4.7–7.6)	6.1 (4.7–7.9)	6.2 (4.0–9.1)	6.1 (4.6–7.9)	5.8 (3.0–9.8)
Non-Hispanic American Indian or Alaska Native	11.5 (7.4–16.8)	12.5 (7.8–18.7)	*	13.9 (7.6–22.7)	*
Non-Hispanic other and multiple races	15.1 (12.2–18.4)	15.4 (12.3–18.9)	16.5 (12.4–21.2)	14.5 (11.0–18.5)	*
Family income as a percentage of FPL ²					
Less than 100% FPL	17.4 (15.6–19.3)	17.6 (15.6–19.7)	15.9 (13.3–18.7)	18.6 (16.5–20.9)	15.5 (12.1–19.4)
100% to less than 200% FPL	17.7 (16.4–19.1)	18.8 (17.2–20.4)	17.9 (15.8–20.3)	19.2 (17.6–20.9)	13.1 (11.0–15.5)
200% to less than or equal to 400% FPL	12.7 (11.9–13.7)	13.7 (12.7–14.8)	12.6 (11.0–14.2)	14.1 (13.0–15.3)	8.6 (7.2–10.2)
Greater than 400% FPL	4.2 (3.8–4.7)	4.5 (4.1–5.0)	3.6 (2.8–4.4)	4.8 (4.3–5.3)	2.8 (2.1–3.6)
Health insurance coverage					
People under age 65 ³ :					
Private	...	8.9 (8.4–9.5)	8.7 (7.8–9.7)	9.0 (8.5–9.6)	...
Medicaid and CHIP	...	14.3 (13.1–15.6)	15.5 (14.0–17.2)	13.1 (11.5–14.7)	...
Other coverage	...	15.0 (12.2–18.2)	*	17.1 (14.1–20.5)	...
Uninsured	...	19.7 (17.8–21.8)	14.8 (10.6–19.9)	20.3 (18.3–22.5)	...
Adults aged 65 and over ⁴ :					
Private	...	...	...	...	4.8 (3.9–5.8)
Dual-eligible (Medicare and Medicaid)	...	...	...	...	11.3 (7.8–15.5)
Medicare Advantage	...	...	...	...	8.9 (7.7–10.3)
Traditional Medicare only	...	...	...	...	9.8 (7.6–12.3)
Other coverage	...	...	...	...	9.1 (6.3–12.6)
Uninsured	...	...	...	...	*
Family education level ⁵					
Less than high school	14.1 (12.0–16.4)	14.9 (12.3–17.9)	12.7 (9.1–17.2)	16.0 (13.4–19.0)	11.8 (9.1–14.9)
High school diploma	14.4 (13.3–15.6)	16.0 (14.6–17.5)	14.7 (12.5–17.0)	16.5 (15.1–18.0)	8.1 (6.7–9.6)
Some college	14.4 (13.4–15.4)	15.3 (14.2–16.5)	17.0 (15.1–18.9)	14.7 (13.7–15.9)	9.6 (8.1–11.2)
Bachelor's degree or more	6.9 (6.4–7.4)	7.1 (6.5–7.7)	7.1 (6.2–8.1)	7.1 (6.5–7.7)	5.7 (4.6–6.8)
Urbanization level ⁶					
Large central metropolitan	9.8 (9.0–10.6)	10.0 (9.1–11.0)	10.3 (8.9–11.9)	9.9 (9.1–10.8)	8.4 (6.7–10.3)
Large fringe metropolitan	9.5 (8.7–10.5)	10.1 (9.1–11.2)	10.0 (8.5–11.7)	10.1 (9.1–11.3)	6.9 (5.7–8.3)
Medium and small metropolitan	11.6 (10.7–12.5)	12.6 (11.5–13.6)	13.1 (11.5–14.8)	12.4 (11.4–13.4)	7.3 (6.1–8.7)
Nonmetropolitan	13.3 (11.9–14.9)	14.5 (12.9–16.4)	13.6 (11.2–16.3)	14.9 (13.2–16.7)	8.6 (7.1–10.4)
Region ⁷					
Northeast	7.5 (6.6–8.4)	7.5 (6.4–8.6)	5.7 (4.3–7.4)	8.1 (6.9–9.3)	7.5 (5.6–9.6)
Midwest	10.7 (9.8–11.8)	11.5 (10.4–12.7)	12.7 (10.8–14.8)	11.1 (10.0–12.2)	7.0 (5.7–8.5)
South	13.2 (12.4–14.1)	14.1 (13.1–15.1)	13.7 (12.3–15.2)	14.2 (13.2–15.2)	9.3 (8.0–10.8)
West	9.2 (8.3–10.0)	9.8 (8.8–10.8)	10.7 (9.1–12.4)	9.5 (8.5–10.5)	5.8 (4.7–7.1)
State Medicaid expansion status ⁸					
Medicaid expansion states ⁹	9.3 (8.8–9.9)	9.8 (9.2–10.4)	9.9 (8.9–10.9)	9.8 (9.2–10.4)	7.0 (6.2–7.9)
Non-Medicaid expansion states ¹⁰	13.5 (12.6–14.4)	14.5 (13.5–15.5)	14.7 (13.1–16.3)	14.4 (13.4–15.5)	9.0 (7.6–10.6)

Table 2. Percentage of people who were in families having problems paying medical bills in the past 12 months, by age group and selected characteristics: United States, 2021—Con.

* Estimate does not meet National Center for Health Statistics standards of reliability.

... Category not applicable.

¹People categorized as Hispanic may be of any race or combination of races. People categorized as non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, and non-Hispanic American Indian or Alaska Native indicated one race only. Non-Hispanic people of multiple or other races are combined into the non-Hispanic other and multiple races category.

²FPL is federal poverty level and was calculated using the U.S. Census Bureau's poverty thresholds for the previous calendar year, which consider family size and age.

³At the time of interview, respondents reported their type(s) of coverage. This information was used to form two health insurance hierarchies: one for people under age 65 and another for adults aged 65 and over. For people under age 65, a hierarchy of four mutually exclusive categories was developed. People with more than one type of health insurance were assigned to the first appropriate category in the following hierarchy: private coverage, Medicaid (includes state-sponsored health plans including the Children's Health Insurance Program [CHIP]), other coverage (includes Medicare, other government, and military coverage), and uninsured.

⁴For adults aged 65 and over, a health insurance hierarchy of six mutually exclusive categories was developed. This hierarchy eliminates duplicate responses for both private health insurance and Medicare Advantage, giving preference to the report of Medicare Advantage. Adults aged 65 and over with more than one type of health insurance were assigned to the first appropriate category in the following hierarchy: private coverage, Medicare and Medicaid, Medicare Advantage, traditional Medicare only (excluding Medicare Advantage), other coverage, and uninsured.

⁵Educational level is based on the highest level of education within a family.

⁶Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 24 in this report). See Methods section in this report for more detail. The large central MSA category has a population of 1 million or more and is similar to an inner city. The large fringe MSA category has a population of 1 million or more and is similar to a suburb. The medium and small MSA category has a population of less than 1 million. The nonmetropolitan category includes those not living in an MSA.

⁷In the geographic classification of the U.S. population, states are grouped into four regions used by the U.S. Census Bureau. Northeast includes: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. Midwest includes: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin. South includes: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. West includes: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

⁸Under provisions of the Affordable Care Act of 2010 (Pub L No 111–48, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of FPL. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2021, 36 states and the District of Columbia have moved forward with Medicaid expansion.

⁹For 2021, states that had expanded Medicaid included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

¹⁰For 2021, states that had not expanded Medicaid included: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

NOTES: Problems paying medical bills is based on a positive response to the question, "In the past 12 months, did you or anyone in the 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." Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2021.

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National Health Statistics Reports ■ Number 180 ■ January 18, 2023

Suggested citation

Cohen RA, Cha AE. Problems paying medical bills: United States, 2021. National Health Statistics Reports; no 180. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: <https://dx.doi.org/10.15620/cdc:122191>.

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