



WILLIAM & MARY
**SCHROEDER CENTER
FOR HEALTH POLICY**

POLICY BRIEF – JULY 2026

Medical Debt in Virginia: Methods and Sources Supplement

This policy brief draws on multiple data sources and analytical approaches to assess the landscape of medical debt policy and its relationship to medical debt outcomes. The methods combine original quantitative analysis with structured review of existing policy resources and background materials.

I. Medical Debt Policy Review

The analysis began with a review of three existing medical debt policy databases. These included a state policy database developed by the Commonwealth Fund, the Medical Debt Policy Scorecard, and a hospital financial policy database maintained by the Lown Institute.

Given the different coverage periods and content of the databases, each was used in different ways.

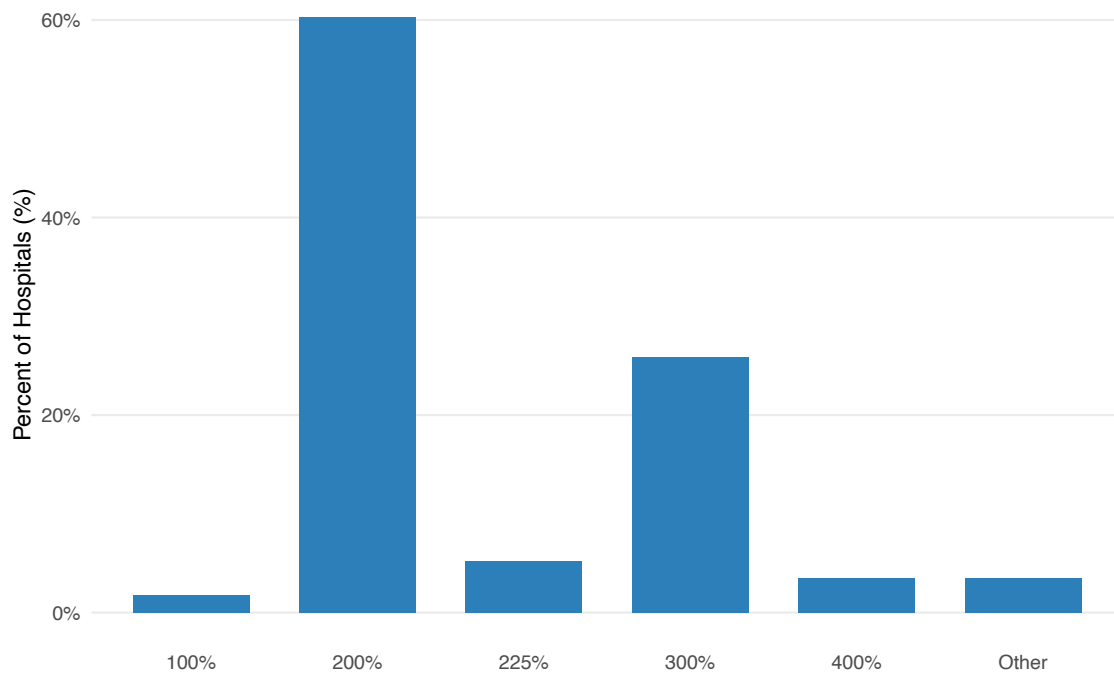
The Medical Debt Policy Scorecard was compiled in 2021 and was used to analyze the association between policy configurations and medical debt levels (see below). Its coverage period does not reflect the most recent policy changes in Virginia but does align with available data on medical debt levels on credit reports collected from the Urban Institute.

The Commonwealth Fund’s “State Protections Against Medical Debt” database was compiled in 2025, so it includes recent medical debt laws passed in Virginia and makes it a better option for comparing trends and practices in state-level approaches to medical debt. Because some of the policies in this database were passed after the most recently-available medical debt measures, it was not used to analyze associations with medical debt levels.

From the Lown Institute, we used the “Hospital financial assistance and debt collection policies” dataset. This hospital-level data was used primarily to assess within-state variation in practices and policies. For instance, Figure 1 illustrates the range of income

thresholds for qualifying for free care across 53 hospitals in Virginia included in the Lown Institute database. While this does not directly measure state-level policy, the hospital-level variation provides important contexts for understanding the landscape within the state.

Figure 1. Income Eligibility Thresholds for Free Care in Virginia Hospitals



Note: Data come from the Lown Institute.

In addition to these aggregated databases, we reviewed statutory and regulatory text related to recent medical debt legislation in Virginia. The recent bills most related to medical debt policy in Virginia include:

- H.B. 34 (2024): Prohibits medical debt collection after three years
- H.B. 1370 (2024): Prohibits reporting of medical debt to consumer credit agencies
- H.B. 1725 (2025): Medical Debt Protection Act

We also conducted state-level case studies of North Carolina, Maine, and New York to better understand the details of recent legislative efforts related to medical debt policies. Key takeaways from the case studies follow:

North Carolina: North Carolina has used federal Medicaid funds to reward hospitals for forgiving or wiping medical debt, via its Healthcare Access and Stabilization Program (HASP). This has allowed NC to alleviate over \$6.5 billion in debt for 2.5 million residents

from July 2024 to October 2025. We find this a particularly promising model, given NC's otherwise similar Medicaid structure to Virginia (both using an MCO model, and both having expanded coverage under the ACA expansion). We base our recommendation for Virginia to forgive medical debt largely on North Carolina's success with this model.

Maine: As of 2024, Maine has adopted a suite of hospital financial assistance policy (FAP) form standardization reforms, effective July 2026. Among the changes are: creating a standardized statewide FAP application form, requiring hospitals to adopt a Medicaid-adjacent modified adjusted gross income (MAGI) methodology to calculate FAP eligibility, standardizing and expanding the free care threshold statewide to 200% FPL, implementing standardized capped payment plans, and requiring applications to be publicized widely and available in various languages. While it is yet to be seen how these changes will affect access to care—and subsequently medical debt—in Maine, the step to pass these laws signals to us that other states are concerned about medical debt proliferation and are taking steps similar to the ones we have proposed in this brief to address the issue.

New York: Effective October 2024, New York requires all hospitals in the state to use a uniform FAP form. NY also has standardized and raised its FAP eligibility threshold to 400% across the state. There has not as of yet been a comprehensive review of these policies' effects, but this mirrors reforms we have proposed in Virginia.

Other States: Two states—Arizona and New Jersey—have partnered with the nonprofit Undue Medical Debt, which buys and forgives discounted bundled medical debt.

II. Analysis of Policy Associations with Medical Debt

To examine the relationship between medical debt policies and medical debt levels, policy indicators from the Medical Debt Scorecard database were linked to measures of medical debt prevalence (% of a state with medical debt) and burden (median amount of medical debt, in dollars). Our team conducted an initial cross-sectional linear regression analysis of the medical debt policies in place across US states in 2021 (using the Medical Debt Policy Scorecard) compared to medical debt in collections data for 2022 (using data from the Urban Institute).

The analysis is cross-sectional, comparing states at a single point in time, and therefore cannot establish a temporal ordering. Results should be interpreted as associations rather than causal estimates, reflecting the observational nature of the analysis and the potential for unobserved confounding.

As Figure 2 shows, there is an observed negative association between aggregated medical debt policy scores and both medical debt share and medical debt amounts. The aggregate

scores represent a summation of a state’s policy indicators across all domains, where a 1 typically indicates the presence of a medical debt policy and 0 indicates an absence. States doing more to address medical debt would therefore have a higher overall score. Although the general directions of the associations are as hypothesized—states with higher medical debt policy scores have lower levels of debt—these results were not statistically significant in bivariate or multivariate regression models. Given the small number of observations and lack of temporal data, uncertainty is high and the figures are best interpreted as motivating further analysis.

Figure 2. Association Between Aggregate Medical Debt Policy Score and Medical Debt, 2022



Note: Aggregate scores come from the Medical Debt Policy Scorecard database and reflect policies as of 2021. Debt levels come from the Urban Institute as of 2022.

To assess the potential associations of individual policies, we relied on lasso regression, which is well-suited to data with many potentially correlated predictors relative to the number of observations. Lasso regression performs variable selection by shrinking less informative coefficients toward zero, resulting in a parsimonious set of variables most associated with the outcome variable. Again, given the small number of observations and lack of longitudinal data, the results should be interpreted with caution and as indicative of correlation only.

As Table 1 shows, only one policy was selected for the lasso regression on share of the population with medical debt. Medicaid expansion was the sole policy associated with a reduction in medical debt levels in the first lasso regression. More policies were selected in the second regression, which predicted the median amount of medical debt for a state. Medicaid expansion was again most predictive, and limitations on pre-judgment interest rates and requirements for charity care were also negatively associated with medical debt amounts. However, there were a number of variables selected with small but positive coefficients, suggesting the data is likely insufficient for teasing out associations for many of the more focused policy indicators.

Table 1. Lasso Regressions of Medical Debt Policy on Medical Debt Share and Amount

Policy	Share with medical debt	Median medical debt amount
Medicaid expansion (ACA)	-0.0206	-170.9315
Limit pre-judgment interest rates	—	-80.9077
Require charity care: means-tested patients	—	-69.4325
Prohibit body attachment/arrest	—	50.6101
Limit garnishments to % of income	—	43.3753
Require billing dispute procedures	—	9.9532
Retroactive benefit extension	—	3.1680
Policies selected	1/36	7/36
Dev. Explained	10.1%	39.3%

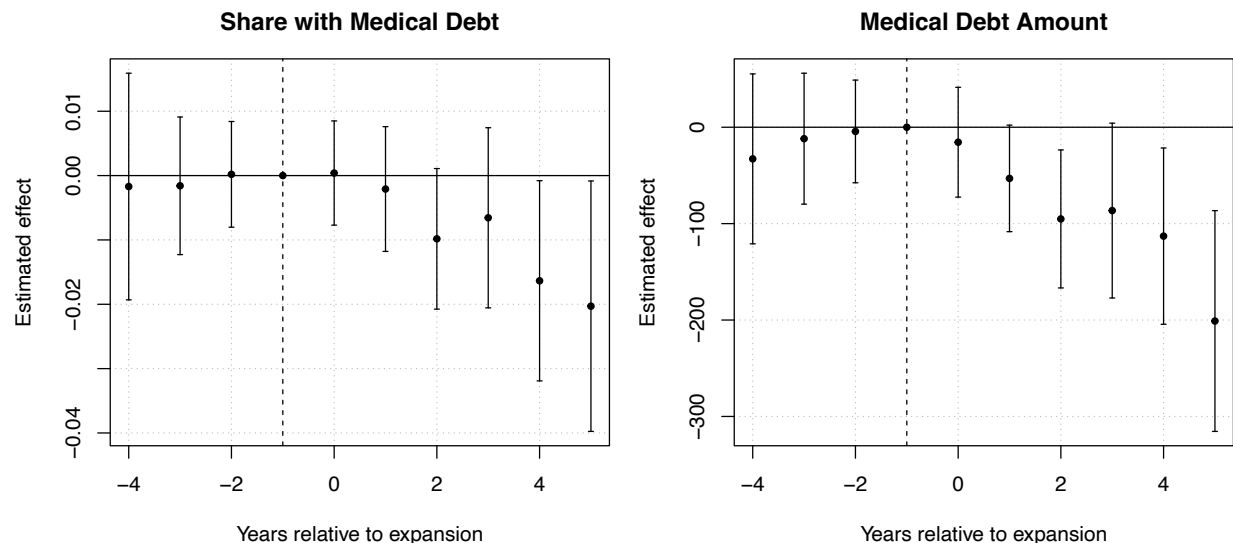
Note: Results based on lasso regressions that shrink non-informative coefficients toward zero. The table presents the remaining variables with significant associations with the share of the state with medical debt and the median amount of medical debt. Policy data comes from the Medical Debt Scorecard in 2021 and medical debt levels from the Urban Institute for 2022.

Given the importance of Medicaid expansion in the lasso regressions, we conducted further analysis of its impact on medical debt. Because of the staggered adoption of Medicaid expansion following the passage of the Affordable Care Act, this was the only policy variable for which we had readily-available longitudinal data on the year and state of adoption. This allowed us to conduct a difference-in-difference event study analysis to better understand how Medicaid expansion affected medical debt at the state level. Using state-level panel data, we compared each state's share of residents with medical debt in the years before and after it expanded Medicaid, relative to the year just before expansion (our reference point). The model includes state fixed effects, to account for stable differences across states, and year fixed effects, to account for national trends that might affect medical debt across all states. This provides a more robust assessment of the association between the policy and outcome than cross-sectional data. Standard errors

are calculated using a heteroskedasticity-robust approach (HC1), which adjusts for the fact that variability in medical debt may differ across states, producing more reliable confidence intervals around our estimates.

Figure 3 below includes the results of the models. In both models, pre-expansion trends (years -4 to -2) show no meaningful difference between expansion and non-expansion states, supporting the credibility of the comparison. Effects on the share of residents with medical debt take several years to emerge, reaching statistical significance by year 4 (a decline of 1.6 percentage points) and year 5 (2.0 percentage points). The pattern is even clearer for average medical debt amounts: declines become significant as early as year 2 (a reduction of about \$95), and grow substantially larger and more statistically robust over time, reaching a decline of roughly \$113 by year 4 and \$201 by year 5. Taken together, the findings suggest that Medicaid expansion did not immediately eliminate medical debt, but instead produced a growing, cumulative reduction in both the prevalence and severity of medical debt over the first several years after states adopted expansion. These findings are important for both understanding declines in medical debt in the 2010s, but also have important implications for forecasting future changes given recent cuts to Medicaid.

Figure 3. Event Study Analysis of Medicaid Expansion on Medical Debt Share and Amount

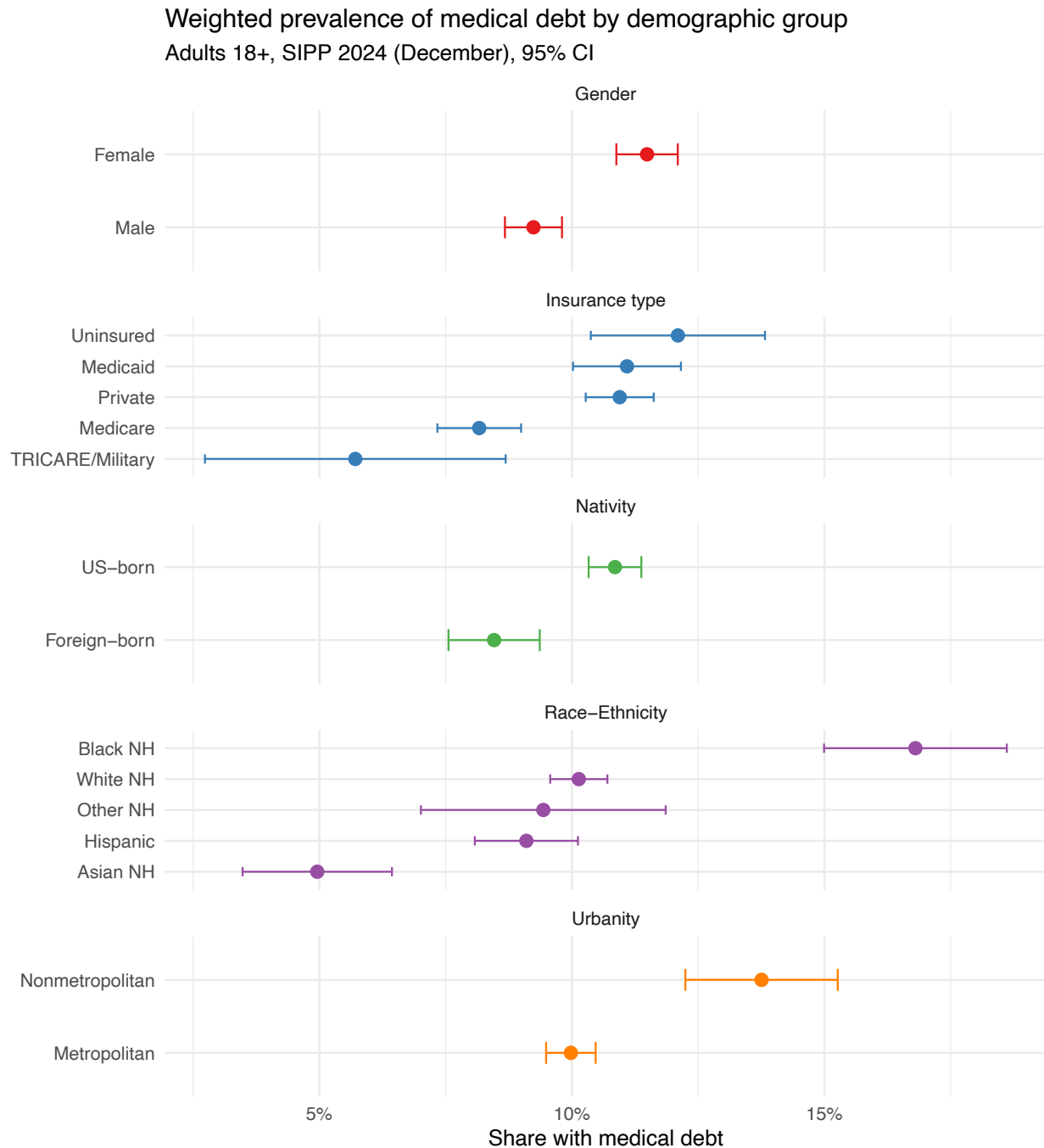


Note: Figures present results of two-way fixed effect event study regression models at the state level. The year before Medicaid expansion is omitted. Medical debt data come from the Urban Institute.

III. Household-Level Analysis Using SIPP Data

The brief also relied on microdata from the Survey of Income and Program Participation (SIPP) to analyze medical debt at the individual and household level. SIPP data were

Figure 4. Medical Debt Patterns in the Survey of Income and Program Participation, 2024



Source: 2024 SIPP Panel

cleaned and weighted using survey-provided weights to ensure national representativeness.

Key variables included measures of medical debt, income, insurance status, and key demographics. Descriptive analyses and regression models were used to examine the distribution of medical debt across income groups and insurance types and to assess disparities across demographic characteristics. Findings from this analysis were used to complement and contextualize state-level results.

In particular, the SIPP allows for an examination of the distribution of medical debt, highlighting key inequalities in the individuals and groups most impacted by debt. As the policy brief notes, “the burden of medical debt is not evenly distributed and broadly reflects patterns of social and economic inequality in society.” Figure 3 highlights the patterns of inequalities in prevalence of medical debt. Income and health insurance status are primary determinants of medical debt, with higher levels seen among those without insurance and with low levels of household income. Controlling for insurance differences, non-Hispanic Black Americans have higher levels of medical debt than other racial groups, and women are disproportionately burdened by medical debt relative to men. The share of adults holding medical debt is also 44% higher in non-metropolitan areas than in metropolitan areas.

IV. Supplemental Research and Background Review

In addition to quantitative analysis, the brief incorporated supplementary research to inform policy interpretation and implementation considerations. This work included a review of hospital financial assistance and charity care application forms in Virginia to assess accessibility, documentation requirements, and administrative complexity.

Our team manually reviewed financial assistance and charity care application forms for Virginia’s top five largest hospital systems by net patient revenue (Sentara Health, Inova, UVA Health, VCU Health, and HCA Healthcare) and select other hospitals across the state (Virginia Hospital Center, Bon Secours). The forms revealed notable differences in content, length, and clarity, as illustrated by the example forms in Figure 5.

Figure 5. Sample Financial Assistance Forms from Virginia Hospitals, 2026

UVA Health, Application for Financial Assistance (page 1 of 3)

APPLICATION FOR FINANCIAL ASSISTANCE  PLEASE MAIL COMPLETED FORM TO:
ATTENTION VERIFICATION DEPARTMENT
BOX 80094
CHARLOTTESVILLE, VA 22908-0750
1-800-229-9659 (P) 1-434-624-1251 (F)
Email: FinancialAssistance@uvahealth.org

STEP 1: COMPLETE INFORMATION BELOW:

PATIENT NAME:	SOCIAL SECURITY # (if applicable):
ADDRESS:	BIRTH DATE:
CITY, STATE, ZIP:	MEDICAL RECORD NO.:
HOME TELEPHONE NUMBER:	WORK TELEPHONE NUMBER:
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED SEPARATED WIDOWED	
ARE YOU A U.S. CITIZEN OR U.S. NATIONAL? YES / NO	
*This information is necessary to determine eligibility for additional benefits/programs.	
IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ONE OF THE IMMIGRATION STATUSES LISTED BELOW? YES / NO*	
*IF YOU ANSWERED 'NO', SKIP TO STEP 2 (you may still be eligible for assistance). IF YOU ANSWERED 'YES', INDICATE WHICH OF THE FOLLOWING DESCRIBES YOUR STATUS:	
☐ ASYLEE ☐ REFUGEE ☐ SPECIAL IMMIGRANT JUVENILE STATUS (SI) ☐ LEGAL PERMANENT RESIDENT WITH AT LEAST FIVE YEARS OF VA RESIDENCY ☐ RESIDENT OF U.S. SINCE 1996 ☐ VETERAN/ACTIVE U.S. MILITARY/SPOUSE OR PARENT OF VETERAN/ACTIVE U.S. MILITARY	

STEP 2: PLEASE COMPLETE THE FOLLOWING SECTIONS ON INCOME AND HEALTH CARE COVERAGE.
If additional space is needed, please attach a separate piece of paper.

FAMILY MEMBERS - INCLUDE SELF, SPOUSE, CHILDREN UNDER 18	SEX M/F	SOCIAL SECURITY # (if known)	BIRTH DATE	RELATION TO PATIENT	MONTHLY GROSS INCOME (see page 2)	EMPLOYER NAME	EMPLOYER PHONE NO.
				Self			

DO YOU RECEIVE THE FOLLOWING: CHILD SUPPORT **YES / NO** AMOUNT: \$ ALIMONY: **YES / NO** AMOUNT: \$
DO YOU HAVE MEDICARE OR ANY OTHER HEALTH INSURANCE WHICH COVERS ALL OR PART OF THE COST OF YOUR PRESCRIPTION MEDICATIONS? **YES/NO** IF YES, LIST THE INSURANCE NAME BELOW WITH THE MEMBER ID# AND GROUP #:

INSURANCE NAME	MEMBER ID#	GROUP#

STEP 3: PLEASE COMPLETE THE FOLLOWING SECTIONS ON RESOURCES.
If additional space is needed, please attach a separate piece of paper.

CHECKING ACCOUNT NO: YES / NO	BANK NAME:	BALANCE: \$
SAVINGS ACCOUNT NO: YES / NO	BANK NAME:	BALANCE: \$
STOCKS, BONDS, IRAs, 401K, CDs, ETC. YES / NO	BANK NAME:	BALANCE: \$

DO YOU OWN OR ARE YOU CURRENTLY BUYING REAL ESTATE PROPERTY? **YES / NO** CITY/COUNTY: TOTAL ACRES: \$
MORTGAGE AMOUNT: \$ DO YOU LIVE ON THE REAL ESTATE PROPERTY? **YES / NO**
DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDENT OVER 21 WITH A CASH VALUE OR LOAN VALUE? **YES/NO**
IF YES, LIST THE INSURANCE(S) NAMES, POLICY NUMBER AND CASH VALUE:
PERSONAL PROPERTY: **YES / NO** LIST ALL CARS, TRUCKS, MOTORCYCLES, CAMPIERS, MOBILE HOMES, ETC.
IF APPLICABLE, DO YOU RESIDE IN YOUR MOBILE HOME: **YES / NO**

ITEM:	MAKE MODEL	YEAR:	AMOUNT OWED: \$	VALUE: \$

DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH THE UVA HEALTH MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH THE HOSPITAL'S INDIGENT CARE PROGRAM, ANY DRUG MANUFACTURER SPONSORED DRUG ASSISTANCE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF ANY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INS. POLICY, STOCKS OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE THE UVA HEALTH TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING. I AGREE TO IMMEDIATELY NOTIFY UVA WHEN MY INSURANCE, MEDICAL OR PRESCRIPTION AND/OR INCOME CHANGES.

APPLICANT/GUARANTOR SIGNATURE (REQUIRED):	DATE:
SPOUSE'S SIGNATURE:	DATE:

This application was received by UVAHealth Employee: _____ Revised 2/06

Virginia Hospital Center, Financial Assistance Application (page 2 of 2)

Financial Assistance Application

Account #: _____

Patient Information	Spouse or Responsible Party Information
Name: _____	Name: _____
Marital Status: _____	Marital Status: _____
Address: _____	Address: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Total Annual Income: _____	Total Annual Income: _____
Total # of Dependents (including yourself): _____	

Housing	Total Owed	Monthly Pmt	Loans	Total Owed	Monthly Pmt
Mortgage or Rent			Personal		
2nd Mortgage			Student		
Phone			Credit Card		
Electricity			Credit Card		
Gas			Credit Card		
Water/Sewer			Other		
Cable			Other		
Maintenance/Repairs			Other		
Subtotal			Subtotal		

Transportation	Monthly Pmt	Bank Accounts	Monthly Pmt
Vehicle 1 Payment		Checking	
Vehicle 2 Payment		Savings	
Bus/Taxi Fare		Investment	
Fuel		Other	
Subtotal		Subtotal	

Other Insurance	Monthly Pmt
Health	
Life	
Auto	
Home/Apt	
Subtotal	

Food	Monthly Pmt
Groceries	
Dining Out	
Subtotal	

I/we have examined this application and to the best of our knowledge believe that it is true, correct and complete.

Patient: _____

Responsible Party/Spouse: _____

Applied for Medicaid: Yes No

Case Worker Name: _____

Appointment Date: _____

Medicaid #: _____

Green Card: _____

V. Sources

Aborode, A.T., Oginni, O., Abacheng, M., Edima, O., Lamunu, E., Folorunso, T.N., Oko, C.I., Iretiayo, A.R., Lawal, L., Amarachi, R., Badri, R., Bamigbade, G.B., Olanrewaju, O.F., Agwuna, F.O., & Adesola, R.O. (2025, February). Healthcare debts in the United States: a silent fight. *Annals of Medicine & Surgery*. 87(2): p 663-672.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11918610/>

Bielenberg, J., Futrell, M., Stover, B., & Hagopian, A. (2020). Presence of Any Medical Debt Associated With Two Additional Years of Homelessness in a Seattle Sample. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. Vol. 57: 1-10.

<https://doi.org/10.1177/0046958020923535>

Blavin, F., Braga, B., & Karpman, M. (2025, November 11). *Medical Debt Was Erased from Credit Reports for Most Consumers, Potentially Improving Many Americans' Lives*. Urban Institute. <https://www.urban.org/urban-wire/medical-debt-was-erased-credit-records-most-consumers-potentially-improving-many>

Blavin, F., Braga, B., Karpman, M., Gonzalez, D., & Kona, M. (2025, November 18). *Exploring the Early Effects of State Consumer Protection Policies on Medical Debt in Collections*. Urban Institute. <https://www.urban.org/research/publication/exploring-early-effects-state-consumer-protection-policies-medical-debt>

Buettgens, M., Carter, J., Levitis, J., Banthin, J., & Simpson, M. (2025, June). *Reconciliation Bill Would Cut Marketplace Enrollment by over 5 Million People Most States' Enrollment Losses Exceed One-Third*. Urban Institute. <https://www.urban.org/sites/default/files/2025-06/Reconciliation-Bill-Would-Cut-Marketplace-Enrollment-by-over-5-Million-People.pdf>

Carney, Kristen. *Virginia Counties by Population*. (n.d.). CUBIT. https://www.virginia-demographics.com/counties_by_population

Fact Sheet: Medical Debt (2023, June). American Hospital Association. <https://www.aha.org/fact-sheets/2023-06-12-fact-sheet-medical-debt>

Himmelstein, D. U., Dickman, S. L., McCormick, D., Bor, D. H., Gaffney, A., & Woolhandler, S. (2022, September 16). Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US. *JAMA Network Open*, 5(9), e2231898. <https://doi.org/10.1001/jamanetworkopen.2022.31898>

H.R. 1 Cuts Mapping Visualizer. Voices for Virginia's Children. <https://vakids.org/maps>

How H.R. 1, the One Big Beautiful Bill Act, Would Affect the Distribution of Resources Available to Households (2025, June 4). Congressional Budget Office. <https://www.cbo.gov/publication/61469>

Kalousova, L., & Burgard, S. A. (2014, April). Tough Choices in Tough Times: Debt and Medication Nonadherence. *Health Education & Behavior*, 41(2), 155–163. <https://doi.org/10.1177/1090198113493093>

Kona, Maanasa, and Vrudhi Raimugia. (2025, July 16). “State Protections Against Medical Debt: A Look at Policies Across the U.S. in 2025.” Commonwealth Fund.

<https://www.commonwealthfund.org/publications/fund-reports/2025/jul/state-protections-against-medical-debt-look-policies-across-us>.

Lopes, L., Kearney, A., Montero, A., Hamel, L., & Brodie, M. (2022, June 16). *Health Care Debt In The U.S.: The Broad Consequences of Medical and Dental Bills*. KFF.

<https://www.kff.org/health-costs/kff-health-care-debt-survey/>

Lown Institute Hospitals Index. 2025. “Hospital financial assistance and collections policies.” <https://lownhospitalsindex.org/report-hospital-financial-assistance-and-debt-collection-policies/>.

Lyu, W., & Wehby, G. L. (2022). Effects of Virginia’s 2019 Medicaid Expansion on Health Insurance Coverage, Access to Care, and Health Status. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 59.

<https://doi.org/10.1177/00469580221092856>

MacDougall, H., Mork, D., Hanson, S., and Smith, C.H. (2024, March). Rural-urban differences in health care unaffordability. *Journal of Rural Health*. 40(2), 376-385. [doi: 10.1111/jrh.12788](https://doi.org/10.1111/jrh.12788).

McGough, M., Ortaliza, J., Lo, J., & Cox, C. (2026, May 19). *What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles*. KFF.

<https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/>

Medicaid / FAMIS Enrollment. (2024). Virginia Medicaid.

<https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>

Medicaid Coverage in Virginia Counties, 2023. (2025, February 6). Center for Children and Families of the Georgetown University McCourt School of Public Policy.

<https://ccf.georgetown.edu/2025/02/06/medicaid-coverage-in-virginia-counties-2023/>

Medical Debt Policy Scorecard. (2022, May 19). Innovation for Justice.

<https://medicaldebtpolicyscorecard.org/>

Nigro, Liz. (2025, August 28) *Cuts by County: Mapping the Impacts of H.R. 1 on SNAP and Medicaid in Virginia*. Voices for Virginia’s Children. <https://vakids.org/posts/cuts-by-county-mapping-the-impacts-of-h-r-1-on-snap-and-medicaid-in-virginia>

Rural Hospitals at Risk of Closing (2026, January). Center for Healthcare Quality & Payment Reform. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

Schneider, Karl E. (2025, August 29). *An Overview of Medical Debt: Collection, Credit Reporting, and Related Policy Issues*. Congressional Research Service.

<https://www.congress.gov/crs-product/IF12169>

Shultz, B. N., Ahmed, A. M., & Messac, L. (2025, February 5). Medical debt in America, Part II: Financial support for the most vulnerable. *Journal of Hospital Medicine*, 20(6), 645–648. <https://doi.org/10.1002/jhm.70002>

The Changing Medical Debt Landscape in the United States. (2024, July 2). Urban Institute. <https://datacatalog.urban.org/dataset/changing-medical-debt-landscape-united-states>

Vollers, Anna Claire. (2025, November 6). *New Trump administration rule could override state medical debt protections*. Stateline. <https://stateline.org/2025/11/06/new-trump-administration-rule-would-override-state-medical-debt-protections/>