ONLINE APPENDIX

A Calculating County Uninsured Rate for Low-Income Young Adults

To calculate our measure of exposure to the CAFPL, we use the U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE). The SAHIE data provides model-based estimates of health insurance coverage at the state and county level by different demographic characteristics. To construct these estimates, the Census Bureau combines data from multiple sources. For the years 2005-2007, the SAHIE data used information from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) the 2000 Census, Internal Revenue Service, Supplemental Nutrition Assistance Program, and Medicaid/Children's Health Insurance Program. The Census Bureau then estimates a hierarchical Bayesian model that produces estimates for the total number of people and the number of people with health insurance coverage for states and counties within demographic and income groups. From 2008 and onward, the SAHIE data uses information from the American Community Survey instead of the CPS ASEC.

In the SAHIE data, low income is defined as having an income at or below 200% of the federal poverty level (FPL) for counties in CA and having an income at or below 250% of the FPL for counties in Arizona, Oregon, Nevada, and Washington. This difference in the poverty definition is to due to data limitation in the creation of the 2005-2007 SAHIE datasets. In the early years of the SAHIE data program, uninsured estimates at the county level for different income levels used data from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The NBCCEDP had different poverty threshold for different states during these years.[31] Because of this data limitation, we use the different FPL thresholds reported in the SAHIE data for the different states in our sample to define the low-income populations of interest.

[31]For those years, 19 states used 200% FPL while the remaining used 250% FPL. For more information on the SAHIE methodology, see https://www.census.gov/data/datasets/time-series/demo/sahie/estimates-cps.html.

Along with geographic counts of individuals by income category, the SAHIE data has geographic counts of individuals by age group. The SAHIE data has information on the total number and number of insured individuals at the state and county level for the following age categories in the 2005-2007 data: under 65 years, 18 to 64, 40 to 64, 50 to 64, and under 19. Counts are produced for the age categories individually and can be broken out by income and other demographic groups. To create our age group of interest, we use the counts for total number and total number of insured individuals from two of the age category groups, individuals ages 18 to 64 and individuals ages 40 to 64. We then subtract the counts of individuals ages 40 to 64 from the the counts of individuals ages 18 to 64 to get total and insured counts of the number of 18- to 39-year-olds for each county for each income category.

B State Debt and Medical Collection Laws

Online searches of each state legislature's online database of laws indicate that during our study period no state in our sample (California, Arizona, Nevada, Oregon, and Washington) had a specific law or regulation regarding medical collections or medical collection reporting, with the exception of the CAFPL. This includes law that focus on the debt collection industry and laws covering healthcare providers. However, all states had statutes that regulated *general* debt collection activity, which would include medical collections. Each state has laws regarding the licensing of debt collectors. All debt collectors are also subject to the Fair Debt Collection Practices Act, passed in 1978, which governs debt collection activity at the federal level.

Additionally, Appendix B of Fedaseyeu (2020) (independently validated by Fonseca (2023)) provides a summary of all *overall* debt collection laws, which would subsume medical collections during this time period. There are two policy changes that occur in our border states between 2003 and 2010. These are the description verbatim from Fedaseyeu (2020):

1. Oregon: *"Effective January 1, 2006, Oregon authorized the Director of the Department of Consumer and Business Services to conduct investigations into debt collection violations and to serve orders"*

2. Nevada: *"Effective June 13, 2007, Nevada specified a procedure for debt verification that requires debt collection agencies to send certain documents to the debtor to verify the debt. Further, violations of the federal FDCPA were deemed violations of state debt collection laws; in addition, the upper bound on the initial registration fee that the Commissioner of Financial Institutions was authorized to charge was eliminated (the upper bound had been $600 prior to this change"*

Neither of these policy changes make material changes to reporting by debt collection agencies and do not affect the process of firms (in our case, healthcare providers) assigning late bills or debt to third-party debt collectors.

C California County Medically Indigent Programs

A potential concern for our identification strategy is that some California counties altered their medically indigent programs around the same time that the CAFPL was implemented. The most important of these changes is adoption of the Health Care Coverage Initiative (HCCI), a federally supported Medicaid demonstration program that expanded access to primary and specialty care for low-income uninsured adults (State of California, 2010; Kominski et al., 2010; Pourat et al., 2015). Beginning in September 2007 and continuing through the end of 2010, ten counties (Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura) implemented the HCCI program. To qualify, individuals had to be uninsured, ages 19 – 64, have income at or below 200 percent of the federal poverty level, be a U.S. citizen or lawful permanent resident with at least five years of U.S. residency, and be ineligible for other public programs. The program introduced a managed-care model emphasizing preventive care and care coordination, with counties primarily responsible for the medical expenses of eligible enrollees (State of California, 2010; Kominski et al., 2010; Pourat et al., 2015). As the HCCI targeted low-income uninsured adults, this overlaps with a subset of individuals most likely to be affected by the CAFPL.

This population overlap raises a potential threat to our triple-difference design. We find that HCCI counties (i.e., counties that adopted the HCCI program) had somewhat higher baseline uninsured rates than non-HCCI counties (i.e., counties that did not adopt the HCCI program) in 2006. The mean uninsured rate for low-income 18–39 year-olds was 52.7 percent in HCCI counties, compared with 45.0 percent in non-HCCI counties, a difference of 7.7 percentage points (two-sided $p = 0.068$). Consistent with this pattern, both linear probability and logit models indicate a positive but modest association between baseline (2006) uninsured rates and HCCI participation. Thus, HCCI could threaten identification if it generated post-2007 changes that were correlated with our county-level exposure measure and affected the financial outcomes we study.

Recall, our main estimating equation

$$\begin{aligned} Y_{ict} \; &= \beta + \pi\big(CA_c \times Exposure_c \times Post_t\big) + \theta\big(CA_c \times Post_t\big) \\ &\quad + \psi\big(Exposure_c \times Post_t\big) + X_{it}'\gamma + C_{ct}'\omega \\ &\quad + \mu_i + \lambda_c + \tau_t + \varepsilon_{ict}, \end{aligned} \tag{3}$$

where Y_{ict} is the financial outcome for individual i in county c and year t, CA_c equals one for California residents in 2006, $Post_t$ equals one for years after 2006, and $Exposure_c$ is the 2006 uninsured rate for low-income adults ages 18 – 39.

For the HCCI to bias the coefficient on $CA_c \times Exposure_c \times Post_t$, it must generate post-2007 changes that vary with $Exposure_c$ and operate through channels that affect the financial outcomes in our data. In particular, HCCI would need to induce larger changes in counties with higher baseline uninsured rates, thereby creating effects correlated with both $Exposure_c$ and the treatment variable in Equation (3). We investigate this possibility directly.

First, we assess whether HCCI adoption had direct effects on hospital utilization and net revenue, since these are the main provider-level channels through which the program could affect downstream financial outcomes. We use annual hospital financial reports from the California Department of Health Care Access and Information (HCAI), which report utilization and net revenue by payer category, including county indigent programs. Using this data, we test whether county indigent discharges, patient census days, outpatient visits, and net patient revenue changed differentially in HCCI counties after program implementation, and whether any associated changes varied systematically with baseline county-level uninsured rates. For our utilization outcomes, which are counts, we estimate hospital-level Poisson pseudo-maximum-likelihood models of the form

$$\mathbb{E}[Y_{hct} \mid X] = \exp\Big(\delta HCCI_{ct} + \eta\big(HCCI_{ct} \times Exposure_c\big) + \theta_h + \lambda_c + \tau_t\Big), \tag{4}$$

where Y_{hct} is a hospital-level utilization outcome for hospital h in county c and year t, $HCCI_{ct}$ equals one if county c implemented the HCCI in year t, and θ_h, λ_c, and τ_t denote hospital, county, and year fixed effects. For net patient revenue, we estimate the analogous linear

model. Because $Exposure_c$ is measured in percentage points, the interaction coefficient, η, captures the differential HCCI effect associated with a one-percentage-point higher county uninsured rate.

The results, reported in Appendix Table D10, suggest that the HCCI is unlikely to confound our main estimates. Although HCCI adoption is associated with average declines in county indigent utilization, the interaction terms between HCCI and baseline uninsured rates are small, positive, and statistically indistinguishable from zero. Further, we find no statistically significant relationship between HCCI, or the interaction $HCCI_{ct} \times Exposure_c$, and hospital net patient revenue from county indigent programs.

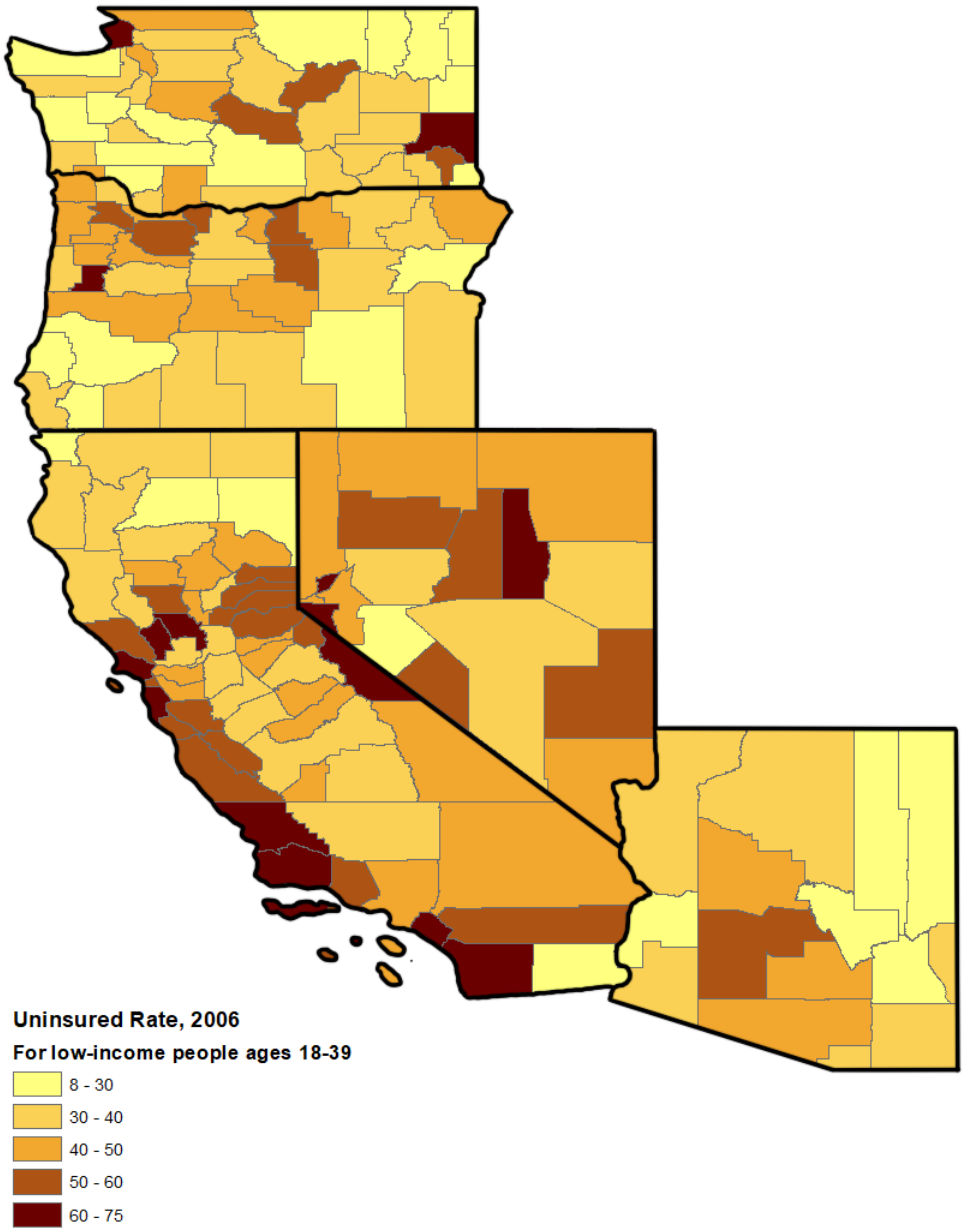
The absence of differential revenue effects is particularly important because the main provider-side confounding channel would likely operate through changes in hospital incentives. For example, if the HCCI changed hospitals' financial position in higher-uninsured counties, hospitals might respond by changing billing intensity, collection practices, or related financial policies in ways that could affect patients' downstream outcomes. We find no evidence of such exposure-dependent revenue effects. This does not rule out all possible individual-level effects of HCCI, but it substantially weakens the hospital-side mechanism through which the program could bias our estimates. This conclusion is reinforced by the small economic importance of county indigent revenue in hospital finances. Using the same HCAI data, we calculate that net revenue from county indigent programs accounts for less than 0.01 percent of total hospital net revenue. It is unlikely that changes to a payer category of this size would induce hospital-wide changes in billing or collection practices, as the marginal benefit of such changes is small relative to the potential administrative costs.

We also test whether our main results are sensitive to excluding the ten HCCI counties. Of note, since our data do not contain income or insurance status, excluding HCCI counties removes both potentially affected HCCI populations and CAFPL-exposed individuals in those counties. Appendix Table D11 and D12 shows that the estimated triple-difference coefficients have the same sign and qualitative pattern as in the full sample, although the point estimates are smaller and the standard errors are larger. This loss of precision is expected because excluding ten California counties reduces both the sample size and the cross-county variation in baseline uninsured rates used to identify our main effect.

The above analysis, taken together, suggests that county indigent program changes are unlikely to explain our main findings. Although HCCI counties had somewhat higher baseline uninsured rates than non-HCCI counties, the hospital-level analysis provides little evidence that the HCCI program induced changes in utilization or hospital revenues large enough to confound our estimates. In addition, the main CAFPL results are qualitatively unchanged when HCCI counties are excluded from the sample. Thus, we believe that our effects are attributable to the CAFPL, and are unlikely driven by HCCI program adoption.

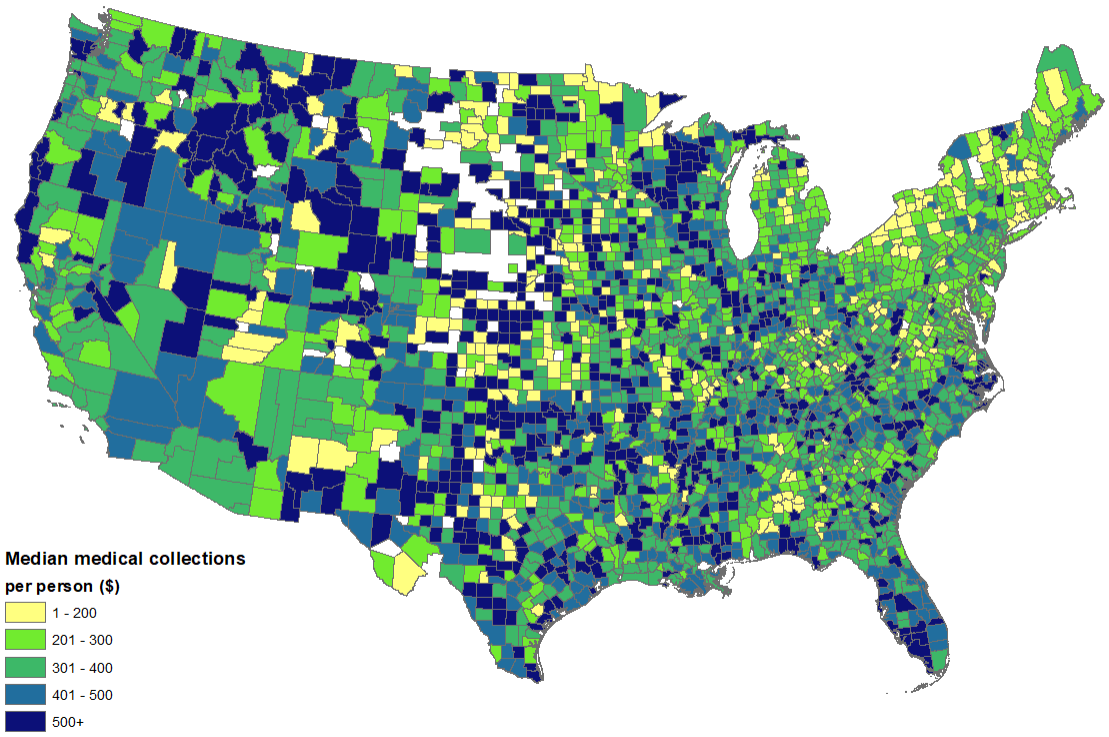
D Figures and Tables

Figure D1: **Uninsured Rate 2006 for California and Border States**



Note: Authors' calculations using U.S. Census Bureau's SAHIE data. Uninsured rates are those for individuals ages 18 – 39 with incomes at or below 200% of the FPL for counties in CA and incomes at or below 250% of the FPL for counties in Arizona, Oregon, Nevada, and Washington.

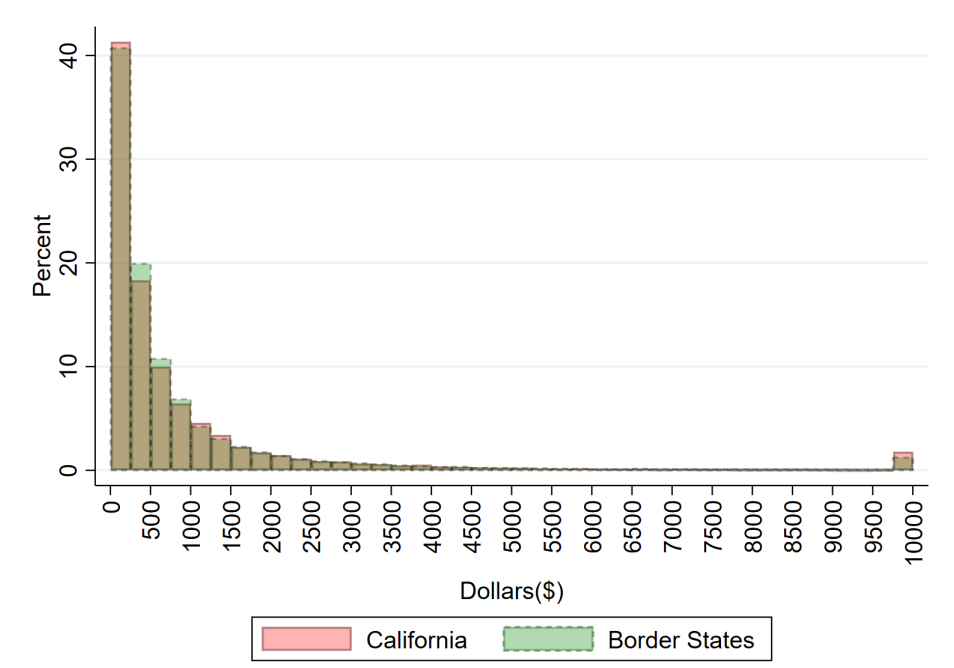
Figure D2: **Median Balance for Recent Medical Collections, 2006**



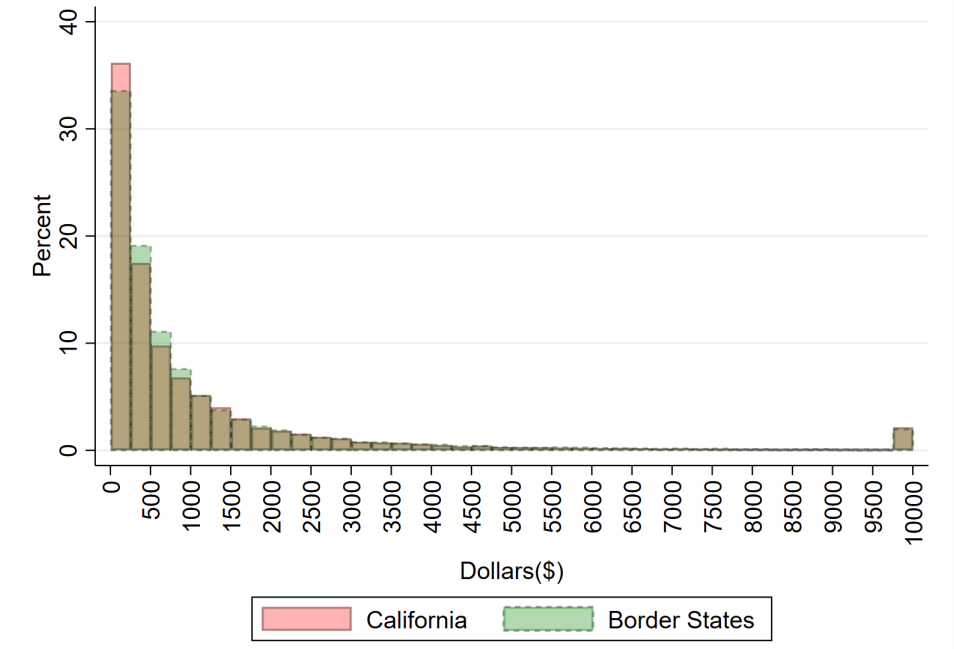
Note: Authors' calculations using Federal Reserve Bank of New York Consumer Credit Panel/Equifax data. Sample includes individuals ages 18 – 39. Recent medical collections are medical bills sent to a third-party debt collector in the past 12 months.

Figure D3: **Medical Collection Balance Distribution, Pre/Post CAFPL**

Panel A: Pre-CAFPL Period



Panel B: Post-CAFPL Period



Note: Authors' calculations using Federal Reserve Bank of New York Consumer Credit Panel/Equifax data. Sample restricted to individuals ages 18 – 39 with positive medical collection balances. Collection dollar amounts above $10,000 windsorized at $10,000.

Table D1: **Effect of CAFPL on Medical and Non-medical Collection Balance Distributions**

Medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	-0.004	-0.009	-0.001	0.014*
	(0.018)	(0.014)	(0.004)	(0.008)
Pre-reform treatment mean	0.962	0.029	0.005	0.005
N	2,258,553	2,258,553	2,258,553	2,258,553

Non-medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
CA × Exposure × Post	0.057**	-0.046***	-0.007	-0.004
	(0.022)	(0.016)	(0.006)	(0.006)
Pre-reform treatment mean	0.894	0.084	0.013	0.009
N	2,203,415	2,203,415	2,203,415	2,203,415

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has a $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Sample includes individuals ages 18 – 39. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties.*** p<0.01, **p < 0.05, *p < 0.1.

Table D2: **Effect of the CAFPL on Financial Distress: Binary Exposure**

	Medical Collections		Non-medical Collections	
	Any	$0 Balance	Any	$0 Balance
Panel A				
CA × Exposure × Post	-0.003	0.002	-0.013**	0.014**
	(0.005)	(0.005)	(0.006)	(0.006)
Pre-reform treatment mean	0.037	0.962	0.106	0.894
N	2,206,325	2,258,480	2,206,325	2,203,340

	Medical Collections		Non-medical Collections	
	Number	Balance	Number	Balance
Panel B				
6 CA × Exposure × Post	-0.004	15.985	-0.037***	-28.926
	(0.014)	(18.521)	(0.011)	(24.806)
Pre-reform treatment mean	0.059	141.33	0.146	289.35
N	2,206,398	2,203,415	2,206,398	778,484

	Risk Score	Share of Debt That Is Delinquent (%)	Number of Delinquent Accounts
Panel C			
CA × Exposure × Post	4.30	-0.022*	-0.0.74*
	(3.022)	(0.012)	(0.039)
Pre-reform treatment mean	653.4	0.153	0.428
N	2,129,443	1,783,128	2,162,338

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *Any* collections variable = 1 if an individual has a positive number of accounts in collections, and the *$0 balance* variable = 1 if an individual has $0 collection balance during the *Post* period. $Treat = 1$ if an individual lives in CA, $Exposure = 1$ if an individual lives in a county that is at or above the median young adult uninsured level, and $Post = 1$ for the years 2007 to 2010. Risk Score is the Equifax Risk Score. Accounts and debts are considered delinquent if they are at least 30 days past due. Sample includes individuals ages 18 – 39. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1.

Table D3: **Effect of CAFPL on Medical and Non-medical Collection Balance Distributions: Binary Exposure**

Medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	0.002	-0.004	0.000	0.002
	(0.005)	(0.004)	(0.001)	(0.002)
Pre-reform treatment mean	0.962	0.028	0.005	0.005
N	2,258,480	2,258,480	2,258,480	2,258,480

Non-medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
CA × Exposure × Post	0.014**	-0.012***	-0.001	-0.001
	(0.006)	(0.004)	(0.002)	(0.001)
Pre-reform treatment mean	0.894	0.084	0.013	0.009
N	2,203,340	2,203,340	2,203,340	2,203,340

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. $Treat = 1$ if an individual lives in CA, $Exposure = 1$ if an individual lives in a county that is at or above the median young adult uninsured level, and $Post = 1$ for the years 2007 to 2010. Sample includes individuals ages 18 – 39. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties.*** p<0.01, **p < 0.05, *p < 0.1.

Table D4: **Effect of CAFPL on Financial Distress: Exclude Oregon**

	Medical Collections		Non-medical Collections	
	Any	$0 Balance	Any	$0 Balance
Panel A				
CA × Exposure × Post	0.007	-0.010	-0.060***	0.063***
	(0.020)	(0.020)	(0.022)	(0.023)
Pre-reform treatment mean	0.033	0.962	0.106	0.894
N	2,028,656	2,076,818	2,028,656	2,026,161

	Medical Collections		Non-medical Collections	
	Number	Balance	Number	Balance
Panel B				
CA × Exposure × Post	0.039	53.472	-0.150***	-40.012
	(0.065)	(98.187)	(0.049)	(139.970)
Pre-reform treatment mean	0.059	141.33	0.146	289.34
N	2,028,730	2,026,237	2,028,730	714,807

	Risk Score	Share of Debt That Is Delinquent (%)	Number of Delinquent Accounts
Panel C			
CA × Exposure × Post	31.147**	-0.136**	-0.416***
	(11.959)	(0.055)	(0.143)
Pre-reform treatment mean	653.5	0.152	0.428
N	1,958,805	1,639,399	1,989,511

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *Any* collections variable = 1 if an individual has a positive number of accounts in collections, and the *$0 balance* variable = 1 if an individual has $0 collection balance during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Risk Score is the Equifax Risk Score. Accounts and debts are considered delinquent if they are at least 30 days past due. Sample includes individuals ages 18 – 39 and excludes individuals living in Oregon. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1.

Table D5: **Effect of CAFPL on Medical and Non-medical Collection Distributions: Exclude Oregon**

Medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	-0.010	0.000	-0.002	0.012
	(0.020)	(0.015)	(0.005)	(0.009)
Pre-reform treatment mean	0.962	0.029	0.005	0.005
N	2,076,818	2,076,818	2,076,818	2,076,818

Non-medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
Treat × Exposure × Post	0.063***	-0.051***	-0.009	-0.004
	(0.023)	(0.016)	(0.007)	(0.006)
Pre-reform treatment mean	0.894	0.084	0.013	0.009
N	2,026,161	2,026,161	2,026,161	2,026,161

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has a $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Sample includes individuals ages 18 – 39 and excludes individuals living in Oregon. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1.

Table D6: **Effect of CAFPL on Financial Distress: 40–64 years**

	Medical Collections		Non-medical Collections	
	Any	$0 Balance	Any	$0 Balance
Panel A				
CA × Exposure × Post	-0.008	0.008	-0.012	0.014
	(0.011)	(0.011)	(0.011)	(0.011)
N	2,688,322	2,768,527	2,688,322	2,678,166

	Medical Collections		Non-medical Collections	
	Number	Balance	Number	Balance
Panel B				
CA × Exposure × Post	-0.007	95.639*	-0.042*	-13.578
	(0.033)	(53.333)	(0.023)	(136.212)
N	2,688,322	2,678,185	2,688,322	666,589

	Risk Score	Share of Debt That Is Delinquent (%)	Number of Delinquent Accounts
Panel C			
CA × Exposure × Post	8.623*	-0.041	-0.157*
	(4.754)	(0.030)	(0.092)
N	2,630,141	2,301,043	2,654,315

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *Any* collections variable = 1 if an individual has a positive number of accounts in collections, and the *$0 balance* variable = 1 if an individual has $0 collection balance during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Risk Score is the Equifax Risk Score. Accounts and debts are considered delinquent if they are at least 30 days past due. Sample includes individuals ages 40 – 64. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1.

Table D7: **Effect of CAFPL on Medical and Non-medical Collection Balance Distributions: 40–64 years**

Medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	0.008	-0.014*	-0.000	0.007*
	(0.011)	(0.007)	(0.003)	(0.004)
N	2,768,546	2,768,546	2,768,546	2,768,546

Non-medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
CA × Exposure × Post	0.014	-0.0118	-0.003	0.002
	(0.011)	(0.008)	(0.004)	(0.003)
N	2,678,185	2,678,185	2,678,185	2,678,185

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has a $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Sample includes individuals ages 40 – 64. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties.*** p<0.01, **p < 0.05, *p < 0.1.

Table D8: **Effect of CAFPL on Financial Distress: No Movers**

	Medical Collections		Non-medical Collections	
	Any	$0 Balance	Any	$0 Balance
Panel A				
CA × Exposure × Post	-0.002	0.000	-0.063**	0.066**
	(0.021)	(0.021)	(0.026)	(0.026)
N	1,658,696	1,707,128	1,658,696	1,659,205

	Medical Collections		Non-medical Collections	
	Number	Balance	Number	Balance
Panel B				
CA × Exposure × Post	0.026	72.659	-0.160***	-93.809
	(0.065)	(94.379)	(0.045)	(113.746)
N	1,658,770	1,659,205	1,658,770	595,541

	Risk Score	Share of Debt That Is Delinquent (%)	Number of Delinquent Accounts
Panel C			
CA × Exposure × Post	26.575*	-0.118**	-0.363**
	(13.557)	(0.054)	(0.158)
N	1,588,997	1,301,886	1,619,319

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *Any* collections variable = 1 if an individual has a positive number of accounts in collections, and the *$0 balance* variable = 1 if an individual has $0 collection balance during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Risk Score is the Equifax Risk Score. Accounts and debts are considered delinquent if they are at least 30 days past due. Sample includes individuals ages 18 – 39 and excludes any individual that changes county during our sample period. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1.

Table D9: **Effect of CAFPL on Medical and Non-medical Collection Balance Distributions: No Movers**

Medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	0.000	-0.015	-0.002	0.016*
	(0.021)	(0.017)	(0.005)	(0.009)
N	1,707,128	1,707,128	1,707,128	1,707,128

Non-medical Collection Balance

	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
CA × Exposure × Post	0.066**	-0.053***	-0.010	-0.003
	(0.026)	(0.019)	(0.007)	(0.005)
N	1,659,205	1,659,205	1,659,205	1,659,205

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has a $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Sample includes individuals ages 18 – 39 and excludes any individual that changes county during our sample period. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties.*** p<0.01, **p < 0.05, *p < 0.1.

Table D10: Effect of HCCI on Hospital Utilization and Patient Revenue

	Discharges	Patient census days	Outpatient visits	Net patient revenue
$HCCI_{ct}$	-0.145	-0.204	-0.351***	-109.454
	(0.185)	(0.170)	(0.137)	(100.584)
$HCCI_{ct} \times Exposure_c$	0.005	0.006	0.006	3.972
	(0.005)	(0.005)	(0.004)	(2.962)
Hospital FE	Yes	Yes	Yes	Yes
County FE	Yes	Yes	Yes	Yes
Year FE	Yes	Yes	Yes	Yes
Estimator	PPML	PPML	PPML	OLS
Clusters (county)	55	55	55	56
Observations	1,998	2,016	1,961	3,071

Notes: Authors' calculations using data from the California Department of Health Care Access and Information and the Census. HCCI is the Health Care Coverage Initiative. Columns (1) to (3) estimated by Poisson pseudo-maximum likelihood (PPML) with county and year fixed effects; column (4) estimated by OLS with county and year fixed effects. Standard errors clustered at the county level in parentheses. $^{***}p < 0.01$

Table D11: **Effect of CAFPL on Financial Distress: No HCCI Counties**

	Medical Collections		Non-medical Collections	
	Any	$0 Balance	Any	$0 Balance
Panel A				
CA × Exposure × Post	0.000	-0.002	-0.033	0.035
	(0.019)	(0.019)	(0.023)	(0.024)
N	1,261,852	1,292,384	1,261,852	1,259,106

	Medical Collections		Non-medical Collections	
	Number	Balance	Number	Balance
Panel B				
CA × Exposure × Post	0.018	90.664	-0.102**	-3.303
	((0.062)	(84.085)	(0.046)	(136.022)
N	1,261,935	1,259,106	1,261,935	500,038

	Risk Score	Share of Debt That Is Delinquent (%)	Number of Delinquent Accounts
Panel C			
CA × Exposure × Post	11.784	-0.062	-0.170
	(12.323)	(0.061)	(0.168)
N	1,207,845	1,005,788	1,228,302

Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *Any* collections variable = 1 if an individual has a positive number of accounts in collections, and the *$0 balance* variable = 1 if an individual has $0 collection balance during the *Post* period. $Treat = 1$ if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and $Post = 1$ for the years 2007 to 2010. Risk Score is the Equifax Risk Score. Accounts and debts are considered delinquent if they are at least 30 days past due. Sample includes individuals ages 18 – 39 and excludes individuals living in Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties. *** p<0.01, **p < 0.05, *p < 0.1..

Table D12: **Effect of CAFPL on Medical and Non-medical Collection Balance Distributions: No HCCI Counties**

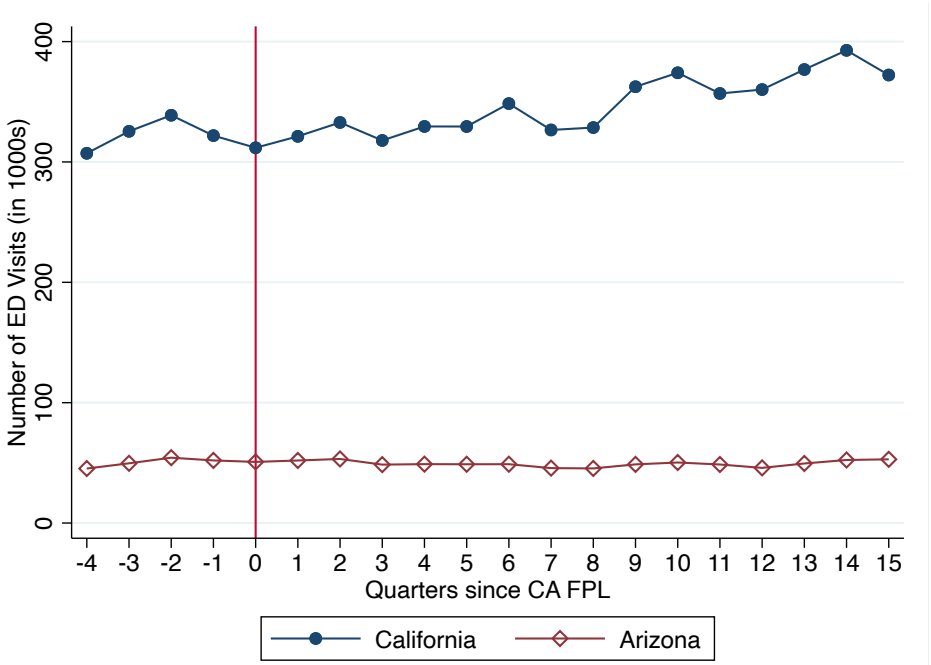
	Medical Debt Balance			
	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel A				
CA × Exposure × Post	-0.002	-0.014	-0.001	0.016*
	(0.019)	(0.014)	(0.005)	(0.009)
Pre-reform treatment mean	0.962	0.029	0.005	0.005
N	1,292,384	1,292,384	1,292,384	1,292,384

	Non-medical Debt Balance			
	$0 Balance	$1 to $1,000	$1,001 to $2,000	$2,001+
Panel B				
CA × Exposure × Post	0.035	-0.032*	-0.004	0.0004
	(0.024)	(0.018)	(0.008)	(0.007)
Pre-reform treatment mean	0.894	0.084	0.013	0.009
N	1,259,106	1,259,106	1,259,106	1,259,106

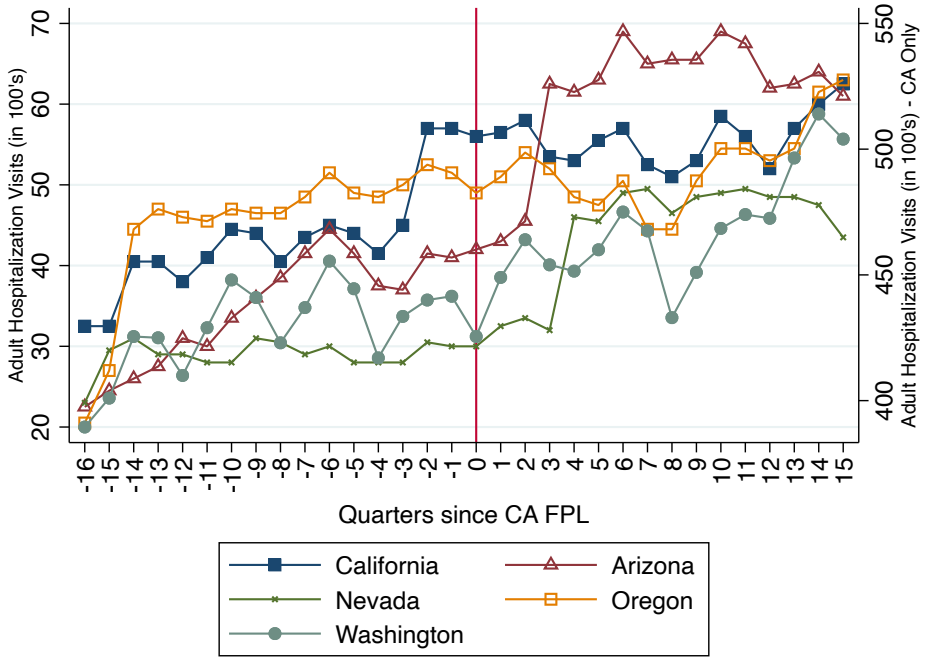
Notes: Authors' calculation using Federal Reserve Bank of New York Consumer Credit Panel/Equifax, Census, FHFA, and BLS data. All collection variables are for accounts sent to a third-party debt collector in the past 12 months. The *$0 balance* variable = 1 if an individual has a $0 collection balance, while the other balance variables = 1 if an individual has a balance in that specific range during the *Post* period. *Treat* = 1 if an individual lives in CA, *Exposure* is a continuous measure of the county-level low-income young adult uninsured rate in 2006, and *Post* = 1 for the years 2007 to 2010. Sample includes individuals ages 18 – 39 and excludes individuals living in Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties. Standard errors clustered at the county-level. Treatment mean is the pre-policy average for individuals living in CA counties.*** p<0.01, **p < 0.05, *p < 0.1.

Figure D4: **Trends in Utilization**

Panel A: Quarterly Emergency Department (ED) Visits for Self-Pay/No Charge Patients



Panel B: Quarterly Inpatient Hospitalizations for Self-Pay/No Charge Patients



Note: Authors' calculations using HCUP Fast Stats State Trends in Inpatient Stays by Payer and State Trends in Emergency Department Visits by Payer data (AHRQ (2020)).