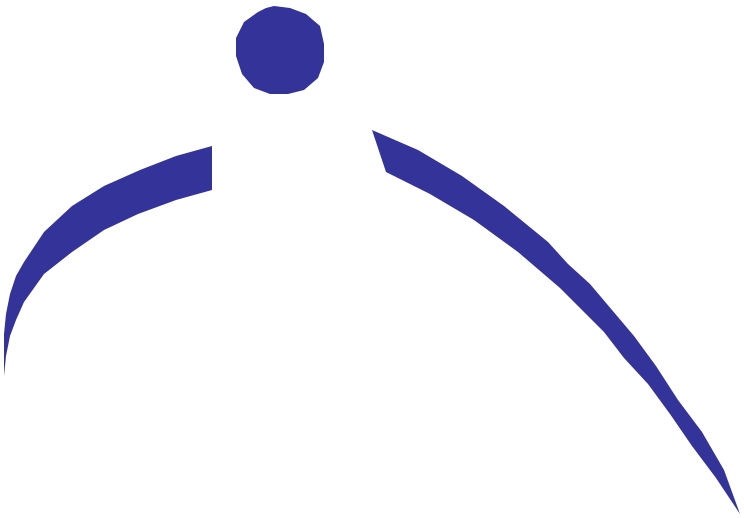

The Consequences of Medical Debt

Evidence from Three Communities

February 2003

---

the access project

Champaign County Health Care Consumers
CCHCC

Human Services Coalition of Dade County, Inc.

Comité de Apoyo de Inquilinos y Trabajadores
Tenants' and Workers' Support Committee

The Access Project (TAP) is affiliated with the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

30 Winter Street, Suite 930
Boston, MA 02108
Phone: (617) 654-9911
E-mail: info@accessproject.org
Internet: www.accessproject.org

The Champaign County Health Care Consumers (CCHCC), founded in 1977, is a non-profit grassroots citizen action organization dedicated to the mission of health care for all. CCHCC is founded on the premise of participatory democracy and the belief that meaningful change in the health care system will come only with the active involvement of consumers. CCHCC works to bring a consumer voice and consumer-driven changes to the health care system through education, advocacy, and community organizing. CCHCC is a community-based organization with over 7,000 members working locally on issues of national importance. CCHCC's staff and its accomplishments have received national recognition, including The Robert Wood Johnson Community Health Leadership Program award. CCHCC has worked with The Access Project since 1999.

44 Main Street, Suite 208
Champaign, IL 61820
Contact person: Claudia Lennhoff
Phone: (217) 352-6533, ext. 11
E-mail: claudia@shout.net
Internet: www.prairienet.org/cchcc/

Founded in 1996, the **Human Services Coalition of Dade County (HSC)** works to empower individuals and communities to create a more just society by promoting civic engagement, economic fairness and access to health and human services. At the heart of these efforts is a belief that families and communities will be strengthened through increased public awareness and civic involvement in improving systems of care. HSC is a membership-based coalition composed of over 6000 members, representing community groups, faith-based organizations, policy makers, businesses and individuals.

260 N.E. 17th Terrace, Suite 200
Miami, FL 33132
Phone: 305-576-5001
E-mail: hsc@hscdade.org
Internet: www.hscdade.org

The **Tenants' and Workers' Support Committee/*Comité de Apoyo de Inquilinos and Trabajadores*** (TWSC/CAIT) is a low-income community-based organization in Alexandria, Virginia. First organized in 1986 in response to the mass evictions of 5,000 low-income Latinos and African-Americans from local neighborhoods, the Committee's mission is to develop the collective power of low-income residents, workers, women, and youth, to challenge racism and sexism through direct action and education, and to promote social change, political leadership, and community ownership and control of resources through grassroots organizing in Northern Virginia. The Committee's Healthy Community program seeks to organize uninsured immigrant community members to improve access to health care in the City of Alexandria.

P.O. Box 2327
Alexandria, VA 22301
Phone: (703) 684-5697
E-mail: silvia_twsc@hotmail.com

ACKNOWLEDGMENTS

Many individuals took part in the planning, research and writing that went into the creation of this report.

In Alexandria, Virginia, the work was coordinated by Silvia Portillo of the Tenants' and Workers' Support Committee, and volunteers who conducted the interviews are Amalia Ruiz, Maria F. Marin, Marina Mendoza, Mauricio E. Hernandez, and Paula Coleto.

In Champaign, Illinois, Claudia Lennhoff of the Champaign County Health Care Consumers coordinated the effort. Volunteers who helped develop the survey instrument, interview consumers, and assist in the creation of the report are Greg Beck, Jodi Berkland, Maqkeia Bess, Ryan Daniels, George Haggard, Jamila McClinton, Don McClure Jr., Eugene Mechtly, Gabe Nunez, Carmen Reid, Jennifer Russano, and Jean Stout. CCHCC staff members Amy Penfold, Brooke Anderson, Bill Mueller, and Paulette Colemon also contributed greatly to all aspects of the project.

In Miami, Florida, Maria Rodriguez coordinated the work for the Human Services Coalition of Miami-Dade County. Those who collected or otherwise assisted with the surveys are Mona Cherestant, Myrian Crissien, Carolyn Chavan, Elena Lozano, Rosario Ruiz, and Sonia Romero-Bravo.

Access Project staff who participated in the project include Meg Baker, Deborah Gurewich, Nancy Kohn, Bill Lottero, Leslie Oblak, Jeffrey Prottas, Carol Pryor, and Robert Seifert. A consultant, Jorge Armesto, conducted the interviewer training in Spanish in Alexandria.

The generous support of the Public Welfare Foundation made this project possible.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Medical debt resulting from needed medical care appears to have serious and long-term effects for individuals and families. For the past year, five partners have worked in three communities to understand the problem of medical debt in terms of how widespread it is and how it affects individuals and families. The five partners are:

- Champaign County (IL) Health Care Consumers
- Human Services Coalition of Miami-Dade County (FL)
- Tenants' and Workers' Support Committee / Comité de Apoyo de Inquilinos y Trabajadores (Alexandria, VA)
- The Access Project
- The Schneider Institute for Health Policy at Brandeis University

The project focused on the very poor and their access to hospital care. We gathered information through interviews with representatives of institutions that serve populations with medical debt, either providing health care services, collecting bills, or providing legal and financial counseling.

We also conducted interviews with individuals who have medical debt. Our preliminary work suggests that hospitals are establishing increasingly aggressive collection policies to pursue payments from patients, regardless of a patient's ability to pay or the magnitude of the debt owed. Medical debt may also be a significant factor in individuals and families seeking credit counseling and filing for bankruptcy. Many of the low-income people we interviewed are adversely affected by medical debt in terms of their access to health care, their overall financial status, their housing and employment, and their material and emotional well-being.

SUMMARY OF KEY FINDINGS:

- Having health insurance does not always protect individuals from out-of-pocket medical bills they cannot afford to pay. In our survey of low-income individuals in three communities, respondents with and without insurance were struggling with comparable levels of medical debt.
- Confusing and multiple bills, and the challenge of understanding what is owed and to whom, add to the problem.
- Provider practices – requiring cash payment upfront, flatly refusing care or suggesting people use other sources of care – made it harder for many respondents with medical debt to access care with any regularity. Patients often responded to these practices by not seeking care or filling prescriptions, or otherwise not complying with treatment regimens.
- Health care providers seem to be adopting more aggressive collection procedures, including turning over their accounts to collection agencies 30 to 60 days after a missed payment (instead of a more customary 150 to 210 days) and encouraging

patients to pay off their medical bills with credit cards, a practice that burdens patients with not only large debts, but high interest payments as well.[1]

- Many of the individuals we interviewed wanted to pay off their debt and had tried to negotiate payment plans, but found the terms of the plan very difficult to maintain given limited incomes and apparently inflexible hospital collection practices.
- Few respondents, in spite of very low incomes, were able to secure public assistance to defray the cost of their medical care. Many turned to family and friends for help, suggesting that communities may help relieve the burden of medical debt, but also share in it.
- Like other forms of debt, medical debt can have substantial financial consequences, including serious credit problems and, in extreme cases, personal bankruptcy. However, unlike other forms of debt, medical debt is often involuntary, the result of an event over which one has little or no control.
- Bankruptcy may offer a means to relief from medical debt and from the harassment of collection agencies and its attendant stress. This is particularly the case for the uninsured – people who are likely to have relatively fewer resources and be less able to make regular payments on their debt.
- Medical debt made it harder for respondents to achieve self-sufficiency; they were hindered in their ability to get a bank loan and other lines of credit, to save money, or to pay for basic goods and services.
- The effects of medical debt can be compounded if a health problem leaves a person unable to return to work. Because of the debt, people may be deterred from seeking the care needed to allow them to work. Job seeking may also be hindered by the fear of wage garnishments.
- Respondents told us that medical debt caused significant stress, anxiety and feelings of hopelessness. Medical debt can also be a source of embarrassment and shame, and many respondents were frustrated and angry that they were being financially punished for a medical event over which they had little control.

Health care is a business unlike most others. The customers are, by definition, in a vulnerable position by virtue of the medical problem for which they seek services. The providers of these services differ from sellers in most other markets because their product is essential and often life saving, and is governed by ethical responsibilities that exceed those that apply in typical commercial transactions. Purchases are often sudden and unplanned and, particularly for people without health insurance, may bring large financial burdens that are involuntary in the sense that they are not the result of a traditional consumer choice.

[1] According to the Association of Credit and Collection Professionals.

To be sure, health care services must be compensated. The uniqueness of the health care marketplace, though, as well as the health care and financial consequences that can result from large debts and aggressive pursuit of payment, argue for a posture of flexibility and accommodation of individual circumstances in negotiating and fulfilling payment arrangements.

I. INTRODUCTION AND BACKGROUND

"A lot has changed in our lives because I do not have money to pay for my wife's operation."[2]

Researchers and policy makers usually consider the problem of being without adequate health insurance in terms of its effects on health access, which are indisputably serious. Left largely unconsidered, though, is another important effect: that people who are uninsured or underinsured often must incur significant and often life-changing debt when they require medical care. Though data exist that demonstrate serious financial burdens from medical debt, research and policy avenues in this area have not been strenuously pursued.

In its 2001 Health Insurance Survey, the Commonwealth Fund found that as many as half of the uninsured had problems paying for their medical expenses, and a third had been contacted by collection agencies regarding unpaid medical bills. Commonwealth further found that such financial problems, though most severe for those without insurance, are not restricted to the uninsured: one out of every six respondents who were continuously insured over the prior year also reported difficulty paying for care or had been contacted by collection agents. In addition, more than one quarter of the currently or recently uninsured had to change their way of life—spend their savings, borrow significantly or forgo or reduce payments for necessities like food and rent—in order to pay their medical bills.[3]

Other national health care surveys show similar results. For instance, Melissa Jacoby and colleagues have also shown health-related expenses to be a significant factor in personal bankruptcies. That study found that about one-third of bankruptcy filers reported substantial medical debt, that health care problems are a factor in half of all consumer bankruptcy filings in the U.S., and that approximately 20 percent of bankruptcy filers lacked health insurance at the time of filing.[4]

In short, a significant portion of the U.S. population faces the challenges of paying for health care and of the debt that results. To date, however, thorough documentation of how the lives of people with medical debt may be altered and exploration of what actions might be required to lessen these effects have not been undertaken to any great extent.
This report describes a project to understand the problem of medical debt in three communities: Alexandria, Virginia; Champaign County, Illinois; and Miami, Florida. Five collaborating organizations developed a research plan designed to begin to determine how widespread the problem is and how it affects people's lives. Our overall goals were to

[2] All quotations are from respondents to the consumer survey conducted in Alexandria, Champaign and Miami, described later in the report.
[3] L. Duchon et al., *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk*. The Commonwealth Fund, December 2001.
[4] Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, "Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts." *NYU Law Review* 76:2 (May 2001)

inform local action to address the problem of medical debt and to develop systematic approaches for learning about medical debt in other communities.

The organizations participating in the project were:

- **Champaign County Health Care Consumers (CCHCC)**: a 25-year-old, non-profit, grassroots membership organization in Champaign, Illinois that involves health care consumers in advocacy for better access to care. A major current CCHCC initiative is its Medical Billing Task Force, of which the research in this report is a part.
- **Human Services Coalition of Miami-Dade County (HSC)**: a non-profit membership coalition composed of over 5,500 individuals and organizations in South Florida. HSC's mission is to support the effective, efficient and humane delivery of health and social services in the community. The research reported here was conducted as part of the Union of the Uninsured initiative, which seeks to empower uninsured, underinsured and underserved people to participate in system reform.
- **Tenants' and Workers' Support Committee/Comité de Apoyo de Inquilinos y Trabajadores (TWSC)**: a low-income community-based organization in Alexandria, Virginia. Its mission is to develop the collective power of low-income residents, workers, women, and youth to promote social change through grassroots organizing. TWSC's Healthy Community Project, begun in 1996 to improve access, mobilize the community and change public policy, was the research partner for this project.
- **The Access Project**: a national initiative that works to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. The Access Project is dedicated to strengthening the voice of underserved communities in the public and private policy discussions that directly affect them.
- **The Schneider Institute for Health Policy at Brandeis University (SIHP)**: a research institute that examines the overall health care system from a variety of perspectives, including questions of access to and quality of care, how health care is financed, delivered, and utilized, and the cost of such care. SIHP and The Access Project have maintained a close affiliation since the latter's inception in 1998.

Our research explored two areas relating to the problem of medical debt. The first was to determine how widespread the incidence of medical debt is among specific groups. Here, we sought to answer questions such as:

- What proportion of a community is burdened with medical debt?
- Is the problem fairly evenly distributed among the uninsured and insured?
- Are there more people with medical debt today than there were five or ten years ago?

To address these and related questions, we conducted a series of interviews with representatives of organizations that serve populations with medical debt in some way: health care providers that may be the source of medical debt, social service agencies that assist clients with a range of problems including medical bills that they cannot pay, and bankruptcy courts where one of the more serious effects of medical debt is exhibited.

The second area we explored focused on individuals with medical debt and how the debt affects different aspects of their lives. Here we asked questions such as:

- Is access to health care more restricted?
- Are there financial repercussions, such as difficulty getting credit?
- Is housing or employment status altered in any way?
- Are there adverse consequences for overall quality of life?

To address these types of questions, we completed a series of consumer surveys, in each of the three communities, of uninsured and insured individuals with medical debt.

II. THE ORGANIZATIONAL INTERVIEWS

We turned to institutions and organizations in the community to give us a sense of the degree to which medical debt creates or exacerbates problems in people's lives. We approached health care providers, legal and financial advisers and social service agencies for information, with varying degrees of success. We came away from these interviews with an impression of the scale of medical debt, some sense of whose lives it touches and how, and directions for further inquiry informed by an appreciation of the complexity of the issue.

We interviewed 33 respondents, representing 21 different organizations, across our three communities. Few could provide us with numerical estimates of the degree to which medical debt affects the people they serve – either the number of people affected or the magnitude of medical debt – but several were able to give impressions and some direction to how we might pursue a more systematic assessment of how widespread the problem is. These interviews were extremely useful in expanding our understanding of the complexity of the problem of medical debt and its different impacts on different segments of the population. The following discussion is organized around three key areas: 1) how widespread the problem is among specific groups; 2) who is affected by medical debt; and 3) data sources and potential areas for future inquiry.

MEASURING THE SCALE OF MEDICAL DEBT

The organizations we spoke with fell into five categories: 1) bankruptcy courts and related debtor attorneys; 2) credit counseling agencies; 3) social services agencies; 4) collection agencies; and 5) hospitals. Each provided a different perspective on the problem of medical debt.

Bankruptcy Courts and Debtor Attorneys

Of the possible financial consequences of medical debt, personal bankruptcy is one of the more extreme. Indeed, according to Melissa Jacoby and colleagues, families arrive at bankruptcy courthouses exhausted emotionally and financially, hoping that the opportunity to discharge some of their debts and restructure others will help stop collection calls, save their homes or their cars from foreclosure and repossession, and give them a chance to stabilize their economic circumstances.[5] There is existing and on-going work based in bankruptcy courts aimed at estimating the prevalence of medical debt among those seeking bankruptcy protection. The most recent study indicates that nearly half of all bankruptcies in 1999 involved a medical problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report health-related bankruptcy.[6] Our community-based work is consistent with these findings:

- In Champaign, the Land of Lincoln Legal Assistance Foundation reviewed the records of bankruptcy cases filed in December 2001 and found that more than half

[5] Jacoby et al.
[6] Jacoby et al.

(58%) of all bankruptcy filings in the Central District of Illinois involved medical debt.

- In Alexandria and Miami, bankruptcy attorneys and legal services offices estimated that between 20 and 30 percent of the bankruptcy cases have a medically-related issue: about half are ascribed to actual medical bills and the other half to a medical incident that interrupts a person's ability to work and maintain a steady income.

A number of factors suggest that these data may underestimate the role of medical debt in bankruptcy. Medical debt, like all debt, is transferable (i.e., a medical expense may be paid off with other forms of debt, such as a credit card or bank loan). Several bankruptcy attorneys believed that some medical debt was probably subsumed in their clients' overall credit card debt, thus making it difficult to accurately assess the full influence of medical debt on personal bankruptcy.

In addition, the debts owed at the bankruptcy stage reflect payment decisions made over a period of time. A person may decide to pay all or a portion of a large hospital bill by taking out a bank loan; the medical debt per se is eliminated (or diminished), but the individual remains burdened with the bank debt, which in turn, may contribute to the bankruptcy story.

Of course, bankruptcy itself is only one of many consequences of debt. Many people laboring under a debt burden never file for bankruptcy.

Consumer Credit Counseling Agencies

To gather information about a broader segment of those with debt, we contacted consumer credit counseling agencies in all three communities. They indicated that medical debt was a common part of their clients' overall debt problem:

- In Champaign and Miami, an estimated 10 percent of those seeking counseling do so primarily because of medical debt and a much higher number (as much as 90 percent in Champaign) are carrying some amount of medical debt, sometimes subsumed in a client's credit card debt.
- In Alexandria, an agency representing one of 11 satellite sites serving 12,000 clients in Northern Virginia, Western Maryland and part of West Virginia, reported that about 50 percent of the cases had medical debt.

Social Service Agencies, Health Care Providers and Collection Agencies

Social service agencies, health care providers, and collection agencies were less useful sources of information with respect to estimating the scale of the problem, but they were helpful in other ways. Hospitals in two out of the three communities provided statistics that reflect the magnitude of unpaid patient bills (one hospital reported $14 million in bad debt and another said that 7 percent of operating costs were bad debt in 2001), but none could

say how many individual patients accounted for these sums. Nationally, hospital bad debt—accounts for which payment is expected but not received—accounted for almost $17 billion, or 4.3 percent of gross revenues in 1998.[7]

Individual-level data from hospitals would illuminate the problem of medical debt for a larger cross-section of the population than information that is available through the other sources we pursued. Data from credit counseling agencies and bankruptcy courts, for instance, reflect the experiences of only a segment of the population. Credit counseling agencies estimate that their clients typically have family incomes of $20,000 to $40,000, suggesting that the very poor do not use these agencies. Bankruptcy-based information may have an even smaller demographic base. Given this, hospitals are an important potential, but not yet fully tapped, information source about the scale of medical debt.

The work with hospitals yielded some information about hospital billing and collection procedures, particularly those focused on the payments due from individual patients (whether insured or uninsured), as opposed to the payments owed by insurers. Through interviews with hospital officials in two of our three communities, we learned that some hospitals either contract for this function or establish a subsidiary solely responsible for collecting payments from individuals. After attempting to collect on a bill for 60 to 90 days, it is not uncommon for a hospital to turn it over to an independent collection agency. This practice of outsourcing bill collection from individuals might permit a hospital to benefit from aggressive collection procedures while maintaining a reputation as a "community" hospital (once outsourced to a collection agency, a hospital bill assumes the name of the collection agency, not the hospital). Hospitals appear to vary, however, with respect to whether the initial collection work is done in-house or via a subsidiary, the timeframe for handing it off to an independent agency, and the aggressiveness with which they pursue payment.

We made attempts to speak with the various hospital divisions and independent agencies that play a role in pursuing collections from individual patients, in order to gain more clarity about this important piece of the medical debt story, but hospitals were reluctant to expose this part of their operation to us. While some good information has come out (for example, according to ACA International, a trade association, the average recovery rate for hospital collections is 6.5 percent and for clinics it is 7.6 percent)[8], this remains an important area to explore. According to a recent New York Times article, "The American Collector's Association says that far more health care providers are turning over their accounts to agencies 30 to 60 days after a missed payment, instead of the customary 150 to 210 days…Doctors, hospitals, laboratories and other health care providers are taking tougher approaches to seeing that bills are paid."[9]

[7] Karen Pallarito, "Bad-debt write-offs on the rise." *Modern Healthcare,* February 22, 1999.
[8] ACA International's 2000 *Top Collection Market Survey*.
[9] Jennifer Steinhauer, "Money & Medicine: Will Doctors Make Your Credit Sick?" *New York Times,* February 4, 2001.

WHO IS AFFECTED BY MEDICAL DEBT

Medical debt appears to be a problem that affects a wide cross-section of the population, including people both with and without insurance. It is also a problem that is particularly burdensome for the elderly (who need a lot of prescription drugs, which are often not covered by insurance) and people with disabilities (who can have high health care costs and limited incomes). Medical debt seems to have different effects for different groups. For the uninsured and very poor, medical debt may have its greatest significance in terms of access to care. The consumer surveys revealed, for instance, that among this group, in addition to being unable to pay off their debts, many may be asked to pay cash in advance of services or be refused service outright if they owe money for previous care.

For insured populations and those with relatively more assets and access to credit, the problem of medical debt has the potential not only to affect their experience in the health care delivery system, but also to endanger their financial status. Some of the credit counseling agencies report that hospitals are increasingly encouraging patients to pay off their medical bills with credit cards, thus burdening patients with large debts *and* high interest payments. In addition, creditors may take legal action that results in debtors having their wages garnisheed or liens placed on their property.

For both the uninsured and insured, it appears that hospitals engage in aggressive collection practices that do not make distinctions based on individual patient circumstances. In one of our communities, for example, a hospital was seeking to garnish wages from a person living in a homeless shelter. It is hard to imagine who gains from this practice; the hospital is unlikely to yield a significant return on these efforts, and the person in the shelter is faced with yet another obstacle to gaining financial self-sufficiency, particularly if the debt is eventually documented on a credit report.

Some of the bankruptcy attorneys said that their clients without health insurance are more likely than their insured clients to file for bankruptcy for medical reasons. Medical debt is reportedly often a factor in a Chapter 7 bankruptcy, in which a debtor is relieved of all unsecured debt (such as credit card debt) but turns over all nonexempt assets to a trustee. This is in contrast to Chapter 13, where a debtor tries to repay all or part of the debt over time but is also permitted to retain some assets. For the uninsured, who may have larger amounts of medical debt and, at the same time, be less able to make payment towards it, bankruptcy may offer a means (albeit extreme) to find relief from their debt, the constant harassment of collection agencies, and its attendant stress.

DATA SOURCES AND FUTURE RESEARCH

The organizational interviews fostered an appreciation of how complex the problem of medical debt is and the utility of different data sources for understanding different dimensions of the problem. Information from the bankruptcy courts offers an opportunity to understand some of the more extreme impacts of medical incidents, in terms of generating extremely high bills or disrupting a person's ability to earn income. Credit

counseling services, on the other hand, may deal with a broader cross-section of the population with medical debt, counseling both those with and without insurance. In these cases, there is much to learn about how the debt came about and how it affects individual lives. Interviewees generally believed that a lot of medical debt for this group is carried on their credit card charges. Validating this perception is a task that remains.

While neither hospitals nor collection agencies have proven very forthcoming with information, they remain key sources of information about the problem of medical debt. Health care providers' billing and collection behavior is a central part of the story: it is critical to understand what motivates a hospital to aggressively pursue payments from patients who, while wanting to pay their medical bills, may be unable to meet the demands of rigid payment plans. There may be a number of factors that determine a hospital's billing and collection practices, ranging from the demands of operating a financially viable institution in the face of dwindling revenues, to concerns about bond ratings, to satisfying Medicare policies that require hospitals to demonstrate efforts to collect payment before bad debt will be reimbursed. In future work, it will be especially important to explore the role public policy plays in health care provider practices.

In summary, we identified the following broad areas for future inquiry:

- Continue studying the scale of medical debt for different sub-populations, including:
    - analysis of individuals' debts stemming from hospital care, and;
    - the degree to which medical debt is converted to other forms of debt such as credit card charges and loans.
- Examine the regulatory environment—including federal and state laws and regulations as well as financial constraints—that might influence, at least in part, a hospital's billing and collection procedures.
- Document the general billing and collection practices of hospitals and other health care providers independent of and in response to regulatory requirements, to better understand the factors that influence providers' behavior toward the poor.

III. THE CONSUMER SURVEY

The best way to understand the effects of medical debt on people's health care access and financial well-being is to ask the people directly. Access Project research staff worked with the three community organizations to develop the research questionnaire and train community residents as interviewers. The information from these surveys does not allow broad conclusions about the entire community, but what it does tell us about the individual respondents is instructive and, if indicative of a more general phenomenon, quite sobering.

Ninety-two respondents completed the consumer survey (37 from Miami, 30 from Champaign and 25 from Alexandria). The consumer survey in the three communities did not aim to obtain a representative sample, but rather to identify the range of impacts resulting from medical debt. In order to place our findings in context, we provide a brief description of the sample to clarify who we surveyed, followed by an analysis of what they told us.

SURVEY RESPONDENTS

Survey respondents are predominantly young women with one or two children. Only five respondents, representing 6 percent of the sample, are over 65 years old. This is important to note, as nursing home and pharmaceutical expenses, which accrue disproportionately to the elderly, are understood to contribute substantially to the problem of medical debt. Many respondents lack health insurance, which undoubtedly contributes to their medical debt problem, although respondents who have health insurance are struggling with comparable levels of medical debt. Many in the sample also lack a steady income.

- Two thirds (67%) of the sample are women, mainly between the ages of 30 and 49 (51% of the sample), representing households with two or fewer children (73% of the sample). (Table 1.)[10]
- More than two thirds (69%) reported they currently had no health coverage and three quarters (75%) were without coverage some time during the past year. (Table 2.)
- A comparison of respondents with and without health insurance indicates that both groups are burdened with comparable levels of medical debt. (Table 14.)
- Over half the respondents (54%) indicated they are currently unemployed and half (49%) said that they were unemployed when they started owing money for medical bills. (Table 2.)

[10] All data tables appear at the end of the report. The precise wording of questions from the survey is incorporated into the tables.

WHAT THEY OWE AND TO WHOM

Most respondents associated their medical debt with a hospital visit or specific divisions within a hospital. A substantial number also reported owing a primary care provider. One respondent captured a general confusion expressed by many when she said: "***You don't know what you are charged for, it's really confusing***." Indeed, on top of dealing with the sheer magnitude of their debt, many are challenged to understand the sources of their debt as well as to whom they owe it and why. Respondents varied a lot in the amount of debt they had, with some owing less than $500 and some as much as $100,000. Presented in the following sections is the finding that even relatively small amounts of medical debt can have devastating effects for low income individual and families.

- Nearly nine of ten respondents (88%) owed money for a hospital visit. Of these, almost two thirds (62%) attribute the hospital expense to emergency room visits. Two-thirds (67%) reported owing money to a primary care provider. (Table 3.)
- The average respondent owes almost $9,000 in medical bills, but almost one in five owed less than $1,000, while a few owed in excess of $100,000. (Table 4.)
- The average medical expense was incurred four years ago, but the range in the sample was quite substantial: about half the respondents (53%) owed money for less than two years; another one-third (31%) had been carrying the debt between two and five years; and 16% incurred their medical debt over five years ago. (Table 4.)

PROVIDER PRACTICES LIMIT ACCESS FOR PEOPLE WITH MEDICAL DEBT

More than half of the respondents (55%) said that they had experienced obstacles in accessing health care services as a result of owing money for medical care (see Table 5). Many pointed to specific provider practices that made it harder for them to get care. Some respondents are asked to pay cash upfront before a health care provider will serve them, often an amount they cannot afford to pay. Other respondents described health care providers refusing them care altogether, or felt they are treated badly by a health care provider because of the money they owe. Still others describe using different health care providers in an effort to avoid the provider to whom they owe money.

Collectively, these practices discouraged many of our respondents from seeking subsequent care and may help explain why low income populations tend to use fewer health care services.

> ***"(I) tried to get an ear infection treated and they refused to see me. They said I can go to the ER. They won't see me until I pay the bill."***

"I have been told by both a physician and hospital that I needed to pay some of my bill in order to be seen…The receptionist has told me right in front of the other patients."

"(I am) afraid to go to the doctor because I think I will get inadequate care because of the bills."

"Both hospitals say they won't see me if I can't pay a substantial portion of their bill…most of the time, I don't go (to the doctor) because I know I can't afford it."

"Sometimes, because you owe the hospital, it intimidates me to go and seek care for fear they will ask me to pay right there."

- One in three respondents (33%) said that a health care provider refused or delayed care because of money owed for medical bills, and 34 percent were asked to pay cash upfront. (Table 5.)
- Two in five respondents (42%) said that a health care provider made them feel uncomfortable, embarrassed or ashamed because they owed money for medical bills. (Table 5.)
- One third of the respondents (32%) sought care from another health care provider because of owing money for medical bills. (Table 6.)
- Almost half the sample (46%) indicated that owing money for medical bills affected their ability to fill prescriptions. (Table 6.)
- Eight respondents (42% of the respondents who said that the care they received had changed since beginning to owe money) said they had gone without health care since owing money for medical care, and six (32% of this group) said that the quality of the care they received had gotten worse. (Table 6.)

PROVIDERS USE AGGRESSIVE STRATEGIES TO COLLECT PAYMENT

In addition to discouraging them from seeking subsequent care, respondents described the aggressive practices that providers use to collect payment. Among our sample of relatively poor respondents, three out of five (61%) had been contacted by a collection agency about their medical debt. Of these, most were likely to owe relatively large sums (on average, about $12,234) compared to their counterparts who were not contacted by a collection agency ($3,450). (Table 13.) This is consistent with some of the information from the organizational interviews, in which we learned that hospitals might establish different collection standards for different amounts of debt.

For example, one hospital does not initiate any legal actions for debts less than $500. This also means that individuals who suffer from a catastrophic illness (that tends to incur the highest costs) may be more adversely affected by health care providers' collection policies. One respondent, a woman living in a domestic violence shelter, reported that the shelter, with its locked doors, cameras and other security systems provided her a sense of safety and protection not just from her violent ex-boyfriend, but also from the collection agency.

> ***"In the beginning they harassed me and I anguished because they told me that they would send me to court if I didn't pay everything I owed."***
>
> ***"I would like to start fresh and would like to live a pleasant life without having someone calling my house or knocking on my door constantly because of owing money."***
>
> ***"…(the collection agency) contacts me all the time. They call 24-7. I time them. I tell them that I am trying to pay and will call them when I can, but they keep calling me!"***

PAYMENT PLANS DO NOT EASE PROBLEMS ASSOCIATED WITH MEDICAL DEBT

Survey respondents expressed a strong desire to pay off their medical bills and almost half (43%) are making some type of payments towards their debt (see Table 7). Reflecting the generally low income of the sample, though, many experience a tremendous burden in trying to maintain the terms of the health care provider's payment plan. Indeed, many voiced frustration, anger and dismay at how difficult it is to negotiate manageable payment plans with health care providers.

Moreover, even when respondents are making an effort to pay down their debt, these efforts are not always recognized by health care providers in the form of easing access to care.

> ***"…they demanded I pay a certain amount bi-weekly. I couldn't afford it. They didn't want to help. I was willing to pay some money, as much as I could. I don't understand, I'm willing to pay, but it has to be as much as I can pay."***
>
> ***"I made two payments, not sure how much, then quit because they're denying me treatment. Why should I pay when they won't see me?"***
>
> ***"The person who contacted me told me that if I didn't pay $500 I would be jailed and I answered that I couldn't pay $500, that I could pay $100, but the person answered no that it had to be $500."***

- Making payments towards medical debt does not appear to ease barriers to care. Respondents who are making payments experienced no significant differences from those not making payments in terms of the likelihood of being refused care or asked to pay cash upfront.[11]
- More than half the sample (57%) tried to work out a payment plan to pay off their medical debt. (Table 7). Of these, 32 (67%) successfully worked out plans in which the average monthly payment is $56.
- Of those who successfully negotiated a payment plan, 25 percent (8 respondents) were not able to sustain the plan: their circumstances changed in such a way so as to make it difficult for them to keep up the payments. (Table 7.)
- Of those respondents who tried but failed to work out a plan (16 respondents), the main reason was that the health care provider demanded too high a monthly payment (true for 13 respondents, or 80% of this group). (Table 7.)

PROVIDER PRACTICES MAY VARY BY COMMUNITY

Some of our findings suggest that local health care provider practices may vary by community and across health care provider settings. For example, respondents in Miami and Champaign were more likely to report they were asked to pay cash upfront for services than their counterparts in Alexandria. Because of the non-random nature of our respondents, we cannot make definitive conclusions here. These observed differences may simply reflect characteristics within each sample. We note them here, however, because they underscore a general understanding that health care markets are local by nature and what we learn about one community may not directly translate to another.

- Respondents in Alexandria were significantly less likely to report that they were asked to pay cash upfront for health services (8%) than respondents in Miami (33%) and Champaign (59%). (Table 15.)
- Respondents in Champaign were significantly more likely to be refused or delayed care (52%) compared to respondents in Alexandria (32%) and Miami (18%). (Table 16.)

[11] Those respondents who are *not* making any payments, however, are significantly more likely to report that health care providers made them feel uncomfortable, embarrassed or ashamed about owing medical bills when they try to get care (52% compared to 30% of those respondents who are making some payments towards their debt). (Table 8).

Variation across health care provider settings, resulting in different medical debt impacts, surfaced in our organizational interviews as well. In Alexandria, where we spoke with a credit counseling agency representing one of 11 satellite offices serving 12,000 clients in Northern Virginia, Western Maryland and part of West Virginia, about 50 percent of their clients were described as having medical debt. However, the agency reported tremendous regional variation. In Winchester, Virginia, for example, medical debt was very important, possibly because Winchester Medical Center demands full payment within 90 days, regardless of the charge amount or the patient's ability to pay. In contrast, medical debt is understood to be less of an issue for credit counseling clients in Alexandria, Virginia.

ACCESS TO PUBLIC ASSISTANCE IS LIMITED

Despite the fact that many in our sample have very low incomes, few were able to secure public assistance to help defray the cost of their medical care. Some reported that they were ineligible, others found the process for applying for assistance too complicated to negotiate, and still others were never informed about the availability of public assistance. Many, instead, looked to friends and family for help, which suggests that communities may help relieve the burden of medical debt, but also share in it.

"I applied for the charity program but was denied because I had things of value."

"I tried to get an SSI check to help me out. I've been denied. I've tried three times. Every time I go, they say there's not enough information. They had something to do, I had to come back, it's been crazy."

"(Public assistance representatives) asked if I had a car. I said yes. They said we can't help you because you have a car worth more than the amount allowed for a person to get assistance…I need to keep the car because I had to go out and search for a job."

- Over one third of the sample (37%) applied for some type of public assistance (Medicaid, Medicare, Social Security, etc). Only one quarter of these actually got financial assistance. The most common reason reported by respondents for not receiving public assistance was ineligibility for the program they applied for. (Table 9.)
- About a third of the sample (31%) borrowed from a friend or family member to help pay off their medical debts. (Table 9.)

PATIENTS CAN INCUR INTEREST CHARGES ON THEIR MEDICAL DEBT

Consistent with what we learned from the organizational interviews, some of the respondents were encouraged to pay for their medical bills using a credit card, a practice that ultimately increases their overall debt burden because of high interest charges. Moreover, some respondents reported that health care providers themselves, perhaps through subsidiary collection departments, are applying interest charges to outstanding medical bills even while a person is making payments on them. Only a few respondents were actually using credit cards to help pay off their medical debt (6 respondents representing 7% of the sample; Table 9). This relatively low frequency may be due to the fact that very few respondents actually have a credit card. In Alexandria, for example, only 32 percent of respondents have credit cards. If this is representative of the other two communities, then an estimated 28 survey respondents (32% of the *total* sample) would have credit cards and, of these, 6 (21%) would have used them to help pay off medical debt.

"The health care provider sent me a letter saying I could pay using a credit card."

"I was informed that I could pay with a credit card."

"I made a payment plan of $50 per month but the balance never went down because they told me I was just paying the interest."

MEDICAL DEBT CAN RESULT IN BAD CREDIT

Medical debt can have a lasting impact on a person's ability to access lines of credit and, in extreme cases, can contribute to a person filing for bankruptcy. Many respondents reported that their medical debt was documented on their credit report, making it hard if not impossible for them to secure bank loans and credit cards. Without these lines of credit, individuals and families with limited incomes may have difficulty acquiring basic goods and services. In addition to limiting their ability to get loans and credit cards, bad credit owing to an outstanding medical bill can also limit a person's ability to secure housing.

"I was denied (a loan). They told me it was because of my medical bills. I need a loan to pay medical bills, but they deny me a loan because I have medical bills. What am I supposed to do?"

"They wouldn't give me a loan (to buy a home) until I paid a medical bill that was in collection."

"They said we didn't qualify [for a mortgage] because we had debt and that we had to pay all of it and not owe anything…."

"I can't really live where I want to because I wouldn't qualify because of these medical debts."

- Nearly one in six respondents (16%) applied for a loan since acquiring medical debt and of these, over half (eight) were denied the loan (three because of medical debt on their credit report). (Table 10.)
- One in five respondents (21%) indicated they had been denied credit (such as for a purchase of a car or furniture) or credit cards because of medical bills. (Table 10.)
- Eighteen respondents (21%) filed for bankruptcy and of these, 15 (83%) indicated that owing money for medical bills contributed to their need to do so. (Table 10.)
- Close to one in five respondents (18%) have been turned down from renting a house or apartment because of owing money for medical bills, many because medical debt showed up on their credit report (true for 69% of those turned down from a rental opportunity). (Table 11.)
- One in ten respondents (10%) tried to borrow money to buy a home; of these, 63 percent had problems borrowing funds because of their medical debt. (Table 11.)

MEDICAL BILLS MAKE IT HARDER TO MEET OTHER FINANCIAL OBLIGATIONS

Medical debt exacerbates already daunting financial situations, making it that much harder for people to manage their daily living expenses, including basic housing and utility costs.

"I have had to move a lot because with so many medical bills. I keep moving into cheaper and cheaper places to be able to pay bills."

"I was sued by my landlord because I was behind on rent…All that happened because of medical bills. I was behind on everything."

"It wasn't a very big debt but it affected me because it made things tight with all the expenses since my income is low."

"I used to send money to my family and the way things were I couldn't send them anything."

- Owing money for medical bills limits the ability to save money (true for 69% of the sample), pay utility bills (50%), and buy clothes (61%). (Table 12.)
- One in three respondents (34%) said owing money for medical bills made it hard to pay their rent or mortgage. (Table 11.)
- Nearly one in five respondents (18%) said that owing money for medical bills forced them to move. (Table 11.)

MEDICAL DEBT CAN INFLUENCE EMPLOYMENT STATUS

Among the respondents we surveyed, the effects of medical debt on employment ranged from people increasing their work hours in order to meet the increased cost of provider payment plans, to medical debt actually being a deterrent for some in seeking employment for fear that their wages would be garnisheed. As most of our respondents were unemployed, the actual incidence of wages being garnisheed was low, but it clearly remained a fear for many who were aware that some health care providers can do this in an effort to collect outstanding medical bills. The story of a person becoming ill, incurring large medical bills in the process, and being unable to resume work as a result of a disability associated with the medical incident was a recurring and troubling theme as well.

"I've had to look for other work since in the beginning I had to pay $200 per month."

"It has affected me because now I can't work and I can't send money to my family and my children."

"I can't work more hours because of my illness."

"Every day I find letters in my mailbox, always from a collection agency…I don't have the money. I don't know what to say to them. I worry about whether I'll be liable if and when I start working. I wish I won the lottery. I'd pay it all back."

"When (I) start working they will garnish my check because of medical bills therefore I don't want to work. I get unemployment (insurance) instead."

OWING MONEY FOR MEDICAL CARE IS VERY STRESSFUL

When asked how medical debt has changed their overall way of life, respondents consistently and overwhelmingly said that medical debt caused them a great deal of stress and anxiety, and feelings of hopelessness. For many, medical debt adds yet another expense to already tight budgets. To others, it is concurrent with a disability that limits or eliminates their ability to earn an income. For others, it is a source of embarrassment and shame. For still others, there is frustration and anger that they are being punished for a medical event over which they had little or no control:

"I am constantly worrying about my medical debt…I feel hopeless. I am a single mom and I think that in the future I will not be able to better my life."

"I don't feel like going out of my house; I want to be with my eyes closed. And if I go to my part-time work it's because I can't die of hunger."

"Owing money affects every part of your life. You don't stop worrying about it anytime."

"I couldn't sleep…I just slept a few hours and it [the debt] even took my appetite away."

- More than half the sample (52%) reported that medical debt caused them a lot of stress and anxiety due to the pressure of owing money. (Table 12.)
- One quarter of the sample (25%) reported stress due to a general worry about what would happen if they got sick and needed care. They feared that owing money for medical bills would prevent them from getting the health care services they needed in the future. (Table 12.)

IV. CONCLUSIONS

There is a strong tendency to think about health care and health care access as problems in isolation. Taking a community-based approach quickly exposes the fallacy of this view. Health care has ramifications that touch other matters of importance. One way it does this is through its costs. People with medical problems have medical bills. For many of them these bills cannot readily be paid and so they find themselves with medical debt.

Many people working in communities encounter this debt as a serious problem confronting individuals, but it is one largely hidden from the public and policy makers. We began this work to examine the extent of medical debt and its real impacts on people's lives, and to learn what we could about its origins and what might be done about it.

The work is at a preliminary stage; much remains to be learned. But the outlines of the problem seem large and troubling. In the first instance it appears that medical debt is not limited to those without health insurance. People with and without insurance are burdened with medical expenses they cannot afford, although the nature of the burden may vary across these groups.

A second finding is the important role of provider practices. Medical debt can be a significant barrier to receiving subsequent medical services because health care providers who are owed money by patients often ask those patients to pay cash upfront, some providers refuse to provide care altogether to patients who owe them for earlier visits, and some providers act differently toward patients who owe them money, making them uncomfortable or embarrassed. The cumulative effect of these experiences is that medical debt disrupts continuity (and, therefore, quality) of care in that it can cause people to change health care providers or to defer needed care. Being ill is the root cause of medical debt but having medical debt makes it harder to obtain adequate care. This implies a disturbing, self-perpetuating cycle.

A third finding is that medical debt has effects that extend well beyond a person's access to health services. It seems to make a significant contribution to the financial problems families face. Like many forms of debt, medical debt plays a role in limiting access to credit (and, in extreme cases, causing bankruptcy), restricting housing opportunities, and creating general and substantial stress and anxiety. However, unlike other types of debt, medical debt is largely involuntary. As such, it is a source of enormous frustration, anger and despair for those who are burdened by it. Respondents consistently said that they and their family's lives were being unfairly punished for a medical event over which they had no control.

A final dimension of our work sought to understand the factors that influence health care providers to adopt the practices they do. Here we sought to learn the institutional sources of medical debt. We focused on hospitals, although independent practitioners are clearly also a source. Many of the individuals we interviewed wanted to pay off their debts, tried to negotiate payment plans, but found the terms of the plan very difficult to maintain given

their tenuous financial circumstances. Some respondents were making efforts to pay off their debt but one missed payment or one payment below the established payment plan resulted in collection notices and, in extreme cases, court action. Exacerbating the problem is that hospitals are adopting increasingly aggressive collection procedures, including turning over their accounts to collection agencies 30 to 60 days after a missed payment. Our respondents' experiences were that health care providers seem to pursue indiscriminately aggressive collection practices and are often less than accommodating in helping patients meet their obligations with, for example, manageable payment plans. Health care providers are also known to encourage patients to transfer their debts to a credit card.

Our preliminary work suggests several areas for further inquiry. We need to better understand the scale of the problem of medical debt: how many people are burdened with medical expenses they cannot afford and how does the burden vary in different population groups? Medical debt transcends both insurance and poverty status in that an unexpected and catastrophic health incident can have significant and adverse non-medical effects; we are all at risk. From a policy perspective, understanding the scale of the problem and broadening the base of constituents who have a stake in the issue could be beneficial.

It is also essential to understand the regulatory environment that influences, at least in part, a health care provider's billing and collection procedures. Federal and state laws and regulations, as well as financial and private insurer constraints all play a role in shaping a health care provider's practices around patient charges, determination of free care and bad debt, and overall collection processes. Further examination of these factors will inform possible policy options for addressing the problem of medical debt.

People who need health care and who have limited means to pay for it often face a steep challenge simply to find someone to provide the care. The financial consequences that may result from receiving needed medical treatment can also affect an individual's health and well-being in profound ways. It is a heavy, and unnecessary, burden.

APPENDIX A: SURVEY TABLES

These 16 tables report results from the consumer interviews conducted in Alexandria, Champaign and Miami. The wordings of the actual questions from the survey are included in the tables.

Table 1. Respondent Demographics

	Number of Respondents	Percent of Sample
Gender		
Male	29	33%
Female	60	67%
Total	89	100%
Age		
18 to 29 years	17	19%
30 to 49 years	45	51%
50 to 65 years	22	25%
Over 65 years	5	6%
Total	89	100%
Number of Children		
None	33	38%
1 or 2	30	35%
3 or 4	15	17%
5 or more	9	10%
Total	87	100%

Table 2. Insurance and Employment Status		
Do you have health insurance?	**Number of Respondents**	**Percent of Sample**
Yes	27	31%
No	61	69%
Total	88	100%
Have you or your family had insurance continuously for the last year?		
Yes	21	25%
No	64	75%
Total	85	100%
Are you currently employed?		
Employed	37	46%
Unemployed	43	54%
Total	80	100%
Were you employed when you started owing money for medical bills?		
Yes	39	51%
No	38	49%
Total	77	100%

Table 3. Source of Medical Debt		
	Number of Respondents	**Percent of Sample (N=89)**
To whom do you owe money because of your medical debt?		
Hospital	78	88%
Primary care provider	60	67%
Lab	30	34%
Pharmacy	9	10%
Ambulance	3	3%

Table 4. Terms and Magnitude of Debt		
	Number of Respondents	**Percent of sample**
How long have you or your family owed this money?		
Less than 1 year	16	19%
1 to 2 years	28	34%
Over 2/less than 5 years	26	31%
5 years or more	13	16%
Total	83	100%
Approximately, how much money do you or your family owe for medical bills (either to healthcare provider or credit card company)?		
Less than $1,000	15	18%
$1,000-$4,999	32	39%
$5,000-$9,999	10	12%
$10,000-$19,999	17	21%
$20,000-$103,000	8	10%
Total	82	100%

Table 5. Access to Care Effects		
	Number of Respondents	**Percent of Sample**
Has owing money for medical bills made it harder for you to go and get medical care?		
Yes	48	55%
No	39	45%
Total	87	100%
Has a doctor, clinic or any other medical service refused to treat you or a member of your family or delayed care or postponed care because you owe money to them or someone else for past treatment?		
Yes	28	33%
No	57	67%
Total	85	100%
Have you or your family been asked to pay cash upfront for healthcare services because of owing money for medical bills?		
Yes	30	34%
No	58	66%
Total	88	100%
Refused/delayed care OR asked for cash upfront		
Yes	44	49%
No	45	51%
Total	89	100
Have healthcare providers made you feel uncomfortable, embarrassed or ashamed about owing money for medical bills when you have tried to get care?		
Yes	36	42%
No	49	58%
Total	85	100%

Table 6. Care Utilization Patterns		
	Number of Respondents	**Percent of Sample**
Have you felt you needed to go to other healthcare providers because of owing money for medical bills?[12]		
Yes	19	32%
No	41	68%
Total	60	100%
Has owing money for medical bills affected your and your family's ability to fill prescriptions?		
Yes	39	46%
No	46	54%
Total	85	100%
How has care you receive changed since beginning to owe money[13]		
Seek other providers	5	26%
Quality of care worse	6	32%
Don't seek care	8	42%
Total	19	100%

[12] Numbers based on Champaign and Miami surveys only. Question worded differently in Alexandria survey which made it difficult to interpret.

[13] Categories based on responses to an open-ended question "Has the care you have received changed since beginning to owe money?" 20 respondents indicated "yes" and 19 offered further explanation as to how it had changed.

Table 7. Payment Plans		
	Number of Respondents	**Percent of sample**
Are you currently or have you made any payments?		
Yes	38	43%
No	50	57%
Total	88	100%
Did you try to arrange a payment plan?		
Yes	48	57%
No	37	43%
Total	85	100%
If yes, were you able to work out payment plan?		
Yes	32	67%
No	16	33%
Total	48	100%
Payment plan comments		
On payment plan	12	32%
Plan amount too high	13	35%
Was on plan, could not maintain	8	22%
Waiting for appointment	4	11%
Total	37	100%

Table 8. Making Payments and Provider Treatment			
	Paying	**Not Paying**	**Total**
	Number of respondents (% of sample)		
Have healthcare providers made you feel uncomfortable, embarrassed or ashamed about owing money for medical bills when you have tried to get care?			
Yes	11 (30%)	25 (52%)	36 (42%)
No	26 (70%)	23 (48%)	49 (58%)
Total	37 (100%)	48 (100%)	85 (100%)

Fisher's Exact Test .042 (2-sided)

Table 9. Paying for Medical Debt		
	Number of Respondents	**Percent of sample**
Are you or your family using credit cards to help pay off medical debt? [14]		
Yes	6	7%
No	62	70%
Don't have a credit card	20	23%
Total	88	100%
Have you or your family borrowed money from family or friends to pay the medical bills or other debt you have because of your medical bills?		
Yes	27	31%
No	61	69%
Total	88	100%
Have you or your family applied for any financial assistance programs to help pay your medical debt?		
Yes	33	37%
No	56	63%
Total	89	100%
If yes, did you receive assistance?		
Yes	8	24%
No	25	76%
Total	33	100%

[14] Categories are mutually exclusive. All respondents were asked whether or not they used a credit card to pay off some or all of their medical debt, but not all were asked if they had a credit card. As such, we do not know how many of the respondents who answered "no" actually have a credit card.

Table 10. Loans, Credit and Bankruptcy		
	Number of Respondents	**Percent of sample**
Have you or your family applied for loans since acquiring medical debt?		
Yes	14	16%
No	74	84%
Total	88	100%
Status of loan		
Got loan	5	36%
Denied	5	36%
Denied; medical debt on credit report	3	21%
Other	1	7%
Total	14	100%
Did you need to get a high cost loan (for those who got a loan)?		
Yes	4	80%
No	1	20%
Total	5	100%
Have you or your family been denied credit (such as for purchase of a car or furniture) or credit cards because of medical bills?		
Yes	26	31%
No	59	59%
Total	85	100%
Have you or your family filed for bankruptcy or are you in process of filing for bankruptcy?		
Yes	18	21%
No	69	79%
Total	87	100%

Table 11. Housing Effects		
	Number of Respondents	**Percent of sample**
Has owing money for medical bills made it difficult to pay your rent/mortgage?		
Yes	29	34%
No	49	57%
No housing costs	8	9%
Total	86	100%
Has owing money for medical bills forced you to move?		
Yes	14	18%
No	65	82%
Total	79	100%
Have you ever been turned down from renting a house or apartment because of owing money for medical bills?		
Yes	16	18%
No	71	82%
Total	87	100%
If yes, do you know if the medical debt is included on your credit report?		
Yes	11	69%
No	5	31%
Total	16	100%
Have you or your family tried to borrow money to buy a home?		
Yes	8	10%
No	72	90%
Total	80	100%
[If you have applied for a loan] Did you have any problems getting the loan?		
Yes	5	63%
No	3	36%
Total	8	100%

Table 12. Medical Debt Impacts Quality of Life		
	Number of Respondents	**Percent of sample (N=89)**
Has owing money for medical bills affected your and your family's ability to:		
Take vacations	52	58%
Buy clothing	53	60%
Pay utility bills	43	48%
Save money	59	66%
Composite responses regarding emotional well-being to questions about effects of medical debt		
Depressed	35	39%
Stress Re. owing money	46	52%
Stress Re. if get sick	22	25%
Embarrassed/ashamed	4	5%
Composite responses regarding physical well being to questions about effects of medical debt		
Go without health care	18	20%
Can't work due to injury	10	11%

Table 13. Amount of Debt (Comparison by Collection Agency Contact)				
	Have you or your family been contacted by a collection agency?			
Amount of Medical Debt	Contacted by Collection Agency	Not Contacted by Collection Agency	t-test	Sig.
Mean	$12,234	$3,450	2.919	.005**

** p < .01

Table 14. Amount of Debt and Insurance Status (Comparison by Insurance Status)

Medical Debt	Insured	Uninsured	t-test	Sig.
Mean	$6,720	$10,020	-.863	.391

$p < .05$

Table 15. Asked to Pay Cash Upfront (Comparison by Site)

Have you or your family been asked to pay cash upfront for healthcare services because of owing money for medical bills?

	Alexandria	Champaign	Miami	All Sites
Yes	2 (8%)	16 (59%)	12 (33%)	30 (34%)
No	23 (92%)	11 (41%)	24 (67%)	58 (66%)
Total	25 (100%)	27 (100%)	36 (100%)	88 (100%)

Chi-Square = 15.195 (sig. = .001)

Table 16. Refused or Delayed Care (Comparison by Site)

Has a doctor, clinic or any other medical service refused to treat you or a member of your family or delayed care or postponed care because you owe money to them or someone else for past treatment?

	Alexandria	Champaign	Miami	All Sites
Yes	8 (32%)	14 (52%)	6 (18%)	28 (33%)
No	17 (68%)	13 (48%)	27 (82%)	57 (67%)
Total	25 (100%)	27 (100%)	33 (100%)	85 (100%)

Chi-Square = 7.635 (sig. = .022)

APPENDIX B: METHODOLOGY

This section describes in more detail the methodology used for both the organizational interviews and consumer surveys. We discuss our protocol design, data collection procedures, and analysis plan.

ORGANIZATIONAL INTERVIEWS

There is no easily accessible data on the scope of medical debt. While there has been some work on bankruptcy, the overall issue of the consequences of medical debt appears virtually invisible to official policy-makers and others outside the grass-roots advocacy community. We therefore decided to try to identify possible sources of information on this subject in our three study communities. The categories of interviewees were developed jointly with our local partners and included the following:

- Health care providers to whom money might be owed;
- Collection Agencies;
- Credit Counseling Agencies;
- Bankruptcy Courts and related bankruptcy and debtor attorneys; and
- Social service agencies who may serve populations especially impacted by medical debt

Although communities vary somewhat with respect to the prevalence of these types of organizations, to the extent possible we tried to interview at least one informant from each of these categories in each of our three study communities. Our local partners helped identify relevant contacts, providing names, addresses and phone numbers where possible. Each site also proposed some additional types of informants who might shed light on the extent of medical debt in their community. For example, we interviewed representatives of legal services in Champaign and Miami, and a patient advocate in Miami.

The Access Project / Heller School developed an open-ended survey protocol to guide the interviews and also took the lead in contacting individual respondents, scheduling meeting times, and completing interviews. The interview protocol focused on five key areas: 1) the degree to which medical debt affects the organization's own clients; 2) the differential effect that medical debt has for people with and without insurance; 3) shifts over time regarding the scale of medical debt; 4) a sense of how widespread the problem is; and 5) potential data sources to quantify the problem of medical debt. With few exceptions, interviews were conducted in person. In a few cases, scheduling conflicts resulted in completing interviews by phone. All interviews were written up as text files and content coded for key study themes.

CONSUMER SURVEYS

The consumer surveys were structured using a questionnaire designed collaboratively with our local partners. The questionnaire went through a number of versions as each partner made suggestions and reviewed versions. The final protocol, used by all partners, was a semi-structured instrument that included both closed- and open-ended questions. The instrument was designed to be relatively easy to administer while also allowing individual respondents to tell their own stories. Survey questions were organized around the following categories of information:

- Background information about the respondent
- Health impacts
- Financial/credit impacts
- Housing impacts
- Employment impacts
- Stress and family impacts

The local partner in each of the three communities fielded the survey using its own staff and volunteers. The Access Project conducted a half-day training at each site – in English in Champaign and Miami, and in Spanish in Alexandria. Our local partners were also responsible for identifying survey participants and implementing the final protocol. Various outreach efforts were used to recruit the final sample including public service announcements, letters and flyers distributed to social service organizations, and review of in-house hotlines to identify people with medical debt. Each site agreed to interview between 25 and 30 respondents. All completed surveys were returned to the Heller School where they were entered into an SPSS data set.

Survey responses were analyzed using both univariate and bivariate techniques. The univariate analysis included basic descriptives and frequencies (for example, how many respondents reported that they were refused medical care because of medical debt?) and the bivariate analysis tested associations between key factors (for example, are respondents who are not making payments on their debt more likely to report difficulties in accessing health services?). T-tests and Chi-Square statistics were used to estimate the statistical significance of these associations.