



# **In Sickness and In Debt**

## **A Review of Medical Debt in Upstate New York**

Trilby de Jung, Esq.  
Empire Justice Center

**January 2006**

*This report was supported by a generous grant from  
Monroe Plan for Medical Care and the New York Bar Foundation.*



Empire Justice is the only statewide, multi-issue, multi-strategy non-profit law firm focused on changing the “systems” within which poor and low income families live. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, we engage in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, we provide legal assistance to those in need and undertake impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.

### **Empire Justice Vision**

To be a statewide leader working to achieve social and economic justice for people in New York State who are poor, disabled or disenfranchised.

### **Empire Justice Mission**

Empire Justice protects and strengthens the legal rights of those who are poor, disabled or disenfranchised through: systems change advocacy, training and support to other advocates and organizations, and high quality legal representation in civil matters.

### **Board of Directors**

**Rene Reixach, Esq.** (Chair)  
**Keith St. John, Esq.** (Treasurer)  
**Amy L. Christensen, Esq.** (Secretary)  
**James W. Lytle, Esq.**  
**JoAnn Smith**  
**Andrea Phoenix, Esq.**

**Tom Maligno, Esq.**  
**Barbara Finkelstein, Esq.**  
**James C. Moore, Esq.**  
**Lauren Breen, Esq.**  
**Daan Braveman, Esq.**  
**Maggie Robb, Esq.**

### **Empire Justice Center**

**Anne Erickson, President/CEO**

**Bryan Hetherington, Chief Counsel**

One West Main Street, Suite 200  
Rochester, NY 14614  
(585) 454-4060

119 Washington Avenue  
Albany, NY 12210  
(518) 462-6831

80 No. Broadway  
White Plains, NY 10603  
(914) 422-4329

## **About the Author and Researcher**

**Trilby de Jung** has been the Health Law Attorney with the Empire Justice Center for three years. Since graduating law school in 1986, she spent several years with the Legal Aid Society in Brooklyn; litigated AIDS discrimination cases for the City of New York; and served as the Deputy Director of Policy for the New York State Department of Health's AIDS Institute. Immediately prior to joining Empire Justice, Trilby taught research and writing at the New York University School of Law.

**Gaurav Sharma** has been an intern with the Empire Justice Center for the past 18 months. During this time, he has devoted himself to interviewing clients, collecting their stories and data, and analyzing the data for this report. Gaurav will graduate in May 2006 from the University of Rochester with majors in Religion and Sociological Studies and minors in Economics and Political Science.

## **Acknowledgments**

Many people are responsible for the production of this report. First and foremost, we would like to acknowledge the contributions of the respondents to this survey, who took time to share with us details of their financial and medical struggles.

Thanks goes to staff at the bankruptcy clinics, who faithfully distributed and collected our surveys, and to intern Ian Donaldson, who created the database we used to collect and enter the information from our surveys. Also, many thanks to all of the Empire Justice staff who lent their time, energy and considerable talents to the seemingly endless statistical analysis, text editing, table formatting, and the myriad of other tasks involved in producing this report. Thanks especially to Michelle Peterson for her tireless – and patient – editing and formatting.

Finally, we are very grateful for the financial support provided by the Monroe Plan for Medical Care and the New York Bar Foundation. Without their contributions this report would not have been possible.

The views expressed in this report are those of the Empire Justice Center and not necessarily those of our funders or board members.

# Table of Contents

<b>Introduction</b>	1
<b>Private Health Insurance:</b>	
Further Out of Reach and Forcing Greater Reliance on Public Safety Net	2
<b>Medical Debt:</b>	
An American Financial Crisis	3
Hospital Billing Practices	3
<b>The New York Context:</b>	
Job Trends, Loss and Private Coverage, Increased Public Coverage and Costs	4
New York’s Charity Care System	5
<b>The Purpose and Scope of This Study</b>	7
Methodology	7
<b>Key Findings</b>	9
<b>Detailed Findings</b>	11
Demographics of the Respondents in General	11
Respondents with Medical Debt Compared to Those Without	11
<i>Figure 1</i>	12
Amount, Sources and Reasons for Medical Debt	13
<i>Figure 2</i>	13
Insurance Coverage	14
Medical Debt and Insurance Statistics	15
<i>Figure 3</i>	15
Consequences of Medical Debt	16
<i>Figure 4</i>	16
Lack of Financial Assistance	18
<i>Figure 5</i>	18
<i>Figure 6</i>	19
<b>Discussion</b>	21
The Size of the Problem	21
The Source of the Debt	21
Who is Medical Debt Likely to Hit	22
Gaps in Coverage Drive Debt	23
Underinsurance and Medical Debt	24
The Impact of Medical Debt	24

# Table of Contents

<b>Recommendations</b>	27
<b>Appendix A: Methodology</b>	30
<b>Appendix B: Tables</b>	32
<i>Table 1: Demographics of ALL Respondents</i>	32
<i>Table 2: Demographics of Respondents with Medical Debt</i>	33
<i>Table 3: Comparison of Respondents With and Without Medical Debt</i>	34
<i>Table 4: Level and Source of Medical Debt Among Respondents</i>	35
<i>Table 5: Comparison by Status of Health Insurance Coverage</i>	36
<i>Table 6: Medical Debt Sources by Status of Health Insurance</i>	37
<i>Table 7: Delays in Needed Care for Respondents with Medical Debt</i>	38
<i>Table 8: How Respondents in Debt Tried to Pay The Medical Bills</i>	39
<i>How Respondents in Debt Tried to Make Ends Meet</i>	39
<i>Table 9: Housing, Employment and Financial Problems</i>	40
<i>Table 10: Financial Assistance</i>	41
<i>Table 11: Employment Problems by Housing Problems</i>	42
<i>Housing Problems by Employment Problems</i>	42
<i>Table 12: Financial Problems by Housing Problems</i>	43
<b>Appendix C: Survey</b>	44

# Introduction

Most Americans believe that our health care system is broken.<sup>1</sup> Health care costs are escalating relentlessly, and a growing number of people find themselves without the means to pay for the health care their families need.<sup>2</sup> Funding for public health insurance programs consumes an ever-growing portion of federal and state budgets, which has led to vociferous debate about how best to reform our health care system.

Many of the current reform proposals are driven by the expectation that the system's current failings can be solved with economic, free market responses. The Bush Administration maintains that a significant number of Americans currently decline or minimize their insurance coverage by choice, and consequently make prudent, cost-based decisions about the health care they ultimately use.<sup>3</sup>

Does reasoning based on free market ideology hold up when applied to low-income Americans? Are families that struggle to make rent payments and put food on the table going without health insurance by choice? Are uninsured and underinsured households on limited budgets making prudent economic decisions about using health care services when confronted with serious illness or injury? This report focuses on these issues through targeted surveys and interviews with low-income individuals living in the most populous communities of upstate New York: Buffalo, Rochester, Syracuse and Albany.

We use Medical Debt as the lens through which to view low-income residents of these communities and their experiences accessing health care. By providing a snapshot of medical debt, we hope to contribute a realistic perspective on how fixed income and medical need operate to limit choices -- and often result in devastating financial consequences.

As we look at Medical Debt and other issues impacting our health care system, it becomes increasingly clear that unless and until we adopt a system of universal health coverage, we will continue to battle dysfunction and dislocation in access to and delivery of vital health care services.

*By providing a snapshot of medical debt, we hope to contribute a realistic perspective on how fixed income and medical need operate to limit choices – and often result in devastating financial consequences.*

---

<sup>1</sup> "National Survey of the Public's Views about Medicaid," conducted in 2005 by Princeton Survey Research Associated with funding by the Kaiser Family Foundation. Available online at: <http://www.kff.org/medicaid/pomr062905pkg.cfm>.

<sup>2</sup> A recent survey found that more than one-third of adults have problems paying medical bills and encounter related problems of access to care. Michelle Doty, et al. "Seeing Red: Americans Being Driven Deeper in Debt by Medical Bills," *Commonwealth Fund*, Aug. 2005.

<sup>3</sup> The President's 2004 Economic Report, available online at [http://www.gpoaccess.gov/usbudget/fy05/pdf/2004\\_erp.pdf](http://www.gpoaccess.gov/usbudget/fy05/pdf/2004_erp.pdf)

## Private Health Insurance: Further Out of Reach and Forcing Greater Reliance on Public Safety Net

As health care costs continue to climb, fewer employers are offering health insurance, and many are shifting more costs to employees. The average family policy cost \$9,950 in 2004, with workers paying an average of \$2,661 toward that cost.<sup>4</sup> For a worker in low wage employment, the cost of that family policy will mean over \$220 a month or more than \$50 a week, a level that is simply unaffordable, even if it is available from the employer.

The number of uninsured Americans increased by 4.6 million between 2001 and 2004, an increase of 11%.<sup>5</sup> The most recent national Census found that between 2003 and 2004 the percentage of people covered by employer-sponsored health plans dropped from 60.4% to 59.8%.

*African-Americans are twice as likely, and Hispanics almost three times as likely to be uninsured as white, non-Hispanic people.*

Not surprisingly, low-income families and racial minorities bear the brunt of the problem. People with annual incomes below \$25,000 are almost three times as likely to be uninsured as those with incomes over \$75,000. African-Americans are twice as likely, and Hispanics almost three times as likely to be uninsured as white, non-Hispanic people.<sup>6</sup>

Increased coverage in public health insurance programs like Medicaid and the State Children's Health Insurance Program (SCHIP) have helped offset the reduction in affordable, employer-based insurance. The percentage of Americans covered by these programs rose from 12.4% in 2003, to 12.9% in 2004. Among children under 18, the percentage rose from 26.4% in 2003 to 26.9% in 2004.

However, just as more people are finding themselves dependent on public health insurance, the federal government is poised to make significant cuts to the Medicaid budget. Some of the changes that Congress is considering, such as mechanisms to lower prescription drug prices, could save money without narrowing coverage. Other proposals, however, such as increases in cost sharing or the imposition of premiums, are likely to shrink enrollment and pass significant costs along to low-income consumers. Many states, including Tennessee, Florida, Missouri and Ohio, have already approved major cuts in their Medicaid programs.

---

<sup>4</sup> "Employer Health Benefits 2005 Annual Survey, Kaiser Family Foundation and Health Research and Education Trust, Sept. 2005. Available online at: [www.kff.org/insurance/7315/index.cfm](http://www.kff.org/insurance/7315/index.cfm)

<sup>5</sup> J. Hadley, et al., "Federal Spending on the Health Care Safety Net from 2001- 2004: Has Spending Kept Pace with the Growth in the Uninsured?" *Kaiser Family Foundation on Medicaid and the Uninsured* (Nov. 2005).

<sup>6</sup> "The Number of Uninsured Americans Continued to Rise in 2004," *The Center for Budget & Policy Priorities*, Aug. 2005 (based on analyses of Census 2004 Current Population data).

## Medical Debt: An American Financial Crisis

*The number of  
medical  
bankruptcies  
filed in this  
country  
increased  
twenty-  
threefold  
between 1981  
and 2001.*

As health costs rise, and comprehensive insurance coverage becomes harder to find or afford, the risk of medical debt looms larger. According to a national study published by Harvard researchers in 2005, the number of medical bankruptcies filed in this country increased twenty-threefold between 1981 and 2001.<sup>7</sup>

Surprisingly, two-thirds of those with medical debt in the Harvard study were insured at the onset of the bankrupting illness.<sup>8</sup> Many cited high co-payments and deductibles for their financial ruin. Very few of those who lost their coverage did so by choice. The majority reported that premiums were unaffordable; others cited difficulty obtaining coverage because of job loss or ineligibility for a family member's employer-sponsored coverage.<sup>9</sup>

Many view hospitals as the ultimate safety net for people unable to get health care, regardless of their ability to pay.<sup>10</sup> While the Hill-Burton Act of 1946 required many community hospitals to provide free or reduced-cost care to those in need for a specified number of years, those legal obligations are expiring. Moreover, hospital care is by no means free. Most families with outstanding medical bills in the Harvard study owed money to hospitals.<sup>11</sup>

### *Hospital Billing Practices*

The consequences to patients unable to pay large hospital bills received national attention during the last five years after a series of articles in the *Wall Street Journal* chronicled the aggressive billing practices of several nonprofit hospitals. Concern about the high rates hospitals charge uninsured patients prompted the U.S. Department of Health and Human Services to clarify the legality of discounts for low-income patients. The American Hospital Association then issued guidelines for billing and collection procedures and asked all member hospitals to review their policies.

Meanwhile, 13 related class-action lawsuits were brought against nonprofit hospitals in seven states on behalf of uninsured patients who were allegedly overcharged and subjected to aggressive billing practices. In 2004, after a year of investigations, the House Energy and Commerce Committee began a series of hearings on hospitals' charging practices in light of their tax-exempt status. While the outcome of the lawsuits has been uneven, the combined

---

<sup>7</sup> D. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* (Web Exclusive. W5) 63 – 73.

<sup>8</sup> *Id.*, at W5-67.

<sup>9</sup> *Id.*, at W5-69.

<sup>10</sup> See, 42 U.S.C.A. § 291(a).

<sup>11</sup> D. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* (Web Exclusive. Site, W5-66).

pressures of Congressional hearings, media attention and potential litigation have led many hospitals to review their billing practices as well as their financial assistance policies.<sup>12</sup>

## **The New York Context: Job Trends, Loss of Private Coverage, Increased Public Coverage and Costs**

New York is subject to the same trends that drive up medical debt nationally: the cost of private insurance puts coverage out of reach; more workers are earning lower wages often without access to health benefits; public programs, both coverage and hospital financing, are stretched to pick up the losses: medical debt sends those without sufficient coverage into a downward financial spiral.

The cost of health care in New York State has mirrored the sharp increases nationally; and jobs with good health insurance benefits have decreased. While manufacturing jobs have declined significantly nationwide, the manufacturing decline in parts of upstate New York has been much steeper than for the U.S. as a whole. Even as we struggle out of a period of job losses, our rate of job growth (1.5%) has trailed the nation's (3.0%) by fifty percent. This is true particularly in Western New York, where any gains that were made were primarily in lower paying jobs.<sup>13</sup>

*New York's  
uninsured rate  
places it  
among the top  
20 states with  
the highest  
uninsured  
rates.*

Nonetheless, New York's uninsured rate actually fell from 16.3% in 2000 to 14.2% in 2004, largely due to a substantial increase in Medicaid and the Family Health Plus program, a Medicaid-funded insurance program designed for low-income working families.<sup>14</sup> Even after this improvement, New York's uninsured rate still places it among the top 20 states with the highest uninsured rates. Our three year average uninsured rate during 2000-2003 was as high or higher than all but 11 states. In 2004, New York's uninsured rate continued to outstrip the uninsured percentage of Massachusetts, Connecticut and Vermont by a third.<sup>15</sup>

Budgetary pressures have made New York's public health insurance programs targets for significant funding cuts. In the past two legislative sessions, New York's legislature approved portions of the Governor's budget designed to reduce spending on public health insurance by increasing co-payments for beneficiaries of

---

<sup>12</sup> For a succinct summary of national activity relating to the consequences of hospital debt, see Weissman, Joel S., "The Trouble with Uncompensated Hospital Care," *New England Journal of Medicine*, 352:12 (March 2005).

<sup>13</sup> "The State of Working New York 2005: Treading Water in a Tenuous Recovery," *Fiscal Policy Institute*, 2005. Available online at: <http://www.fiscalpolicy.org/SOWNY2005.stm>

<sup>14</sup> *Id.*

<sup>15</sup> Estimates by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured, based on pooled March 2003 and 2004 Current Population Surveys. Available online at: <http://www.statehealthfacts.org>.

both Medicaid and Family Health Plus, tightening eligibility criteria, and reducing services within the Family Health Plus program.

As public insurance programs become more and more difficult to access, uncompensated hospital care takes on more importance, often serving as the safety net of last resort. New York is among a handful of states, including Massachusetts and New Jersey, which provide funding for uncompensated care in hospital settings.

### *New York's Charity Care System*

The legislature first created New York's bad debt and charity care pool in 1983, with the goal of redistributing the cost of uncompensated care statewide so that hospitals could provide care without regard to a patient's insurance status.<sup>16</sup> New York continued this funding, renamed the Indigent Care Pool, under the competitive pricing scheme of the Health Care Reform Act (HCRA) of 1996. The Indigent Care Pool was renewed in 1999, 2003 and again in 2005.

Under HCRA, a surcharge is applied to all hospital and clinic visits, including those funded by Medicaid. Pool funds are distributed retroactively to eligible hospitals according to a sliding scale formula based on need.<sup>17</sup> Distributions from the Indigent Care Pool represent the largest expense in HCRA, almost one billion dollars a year.<sup>18</sup>

*The United  
Hospital Fund  
recently  
estimated that  
45% of the  
uninsured in New  
York are actually  
eligible for  
public health  
insurance*

Weaknesses in the mechanism through which HCRA reimburses hospitals for uncompensated care have been noted by providers, government agencies, and consumer advocacy groups. Hospitals point to the retroactive nature of the payment system as problematic. There is often a two-year lag between the provision of services and the receipt of funds from the pool. The fact reimbursement from the Indigent Care Pool is less than 100% is also a frequent criticism.<sup>19</sup>

Losses sustained by hospitals due to uncompensated care could be minimized if enrollment in New York's public health insurance programs were maximized. The United Hospital Fund recently estimated that 45% of the uninsured in New York are actually eligible for public health insurance coverage.

---

<sup>16</sup> K.E. Thorpe, "Does all-payer rate setting work? The Case of the New York Prospective Hospital Reimbursement Methodology," *Journal of Health Politics, Policy & Law*, 1987; 12(3):391-408.

<sup>17</sup> N.Y. Pub. Health L. Sections 2807-c(14)-2807-c(19).

<sup>18</sup> New York State Comptroller's Office, "HCRA: The Need to Restore Accountability to State Taxpayers," Albany, NY (2003).

Available at <http://www.osc.state.ny.us/reports/health/hcra.pdf>.

<sup>19</sup> NYSDOH reports that, on average, hospitals are reimbursed 50% of their indigent care costs by the pool. The cost coverage ranges from below 20% to over 80% for some hospitals. The coverage depends on the formula and rate table established by the NYSDOH, with hospitals that have higher uncompensated care costs as a percentage of total costs receiving more funds. See [http://www.gnyha.org/pubinfo/HCRA\\_QA.pdf](http://www.gnyha.org/pubinfo/HCRA_QA.pdf).

Government agencies and community groups have also registered strong criticism about the lack of transparency for disbursements and services provided under HCRA's Indigent Care Pool. Changes made in the 2005 legislative session require certain disbursement activities to be reported to the Comptroller.<sup>20</sup> However, public access to disbursement information is still problematic. Hospital reporting on services provided remains limited to institutional cost reports, with very little detail on patients served or care provided.<sup>21</sup>

***HCRA's Indigent Care Pool has been criticized for failing to protect those it was intended to benefit most directly -- uninsured and underinsured patients unable to pay their medical bills.***

Perhaps most fundamentally, HCRA's Indigent Care Pool has been criticized for failing to protect those it was intended to benefit most directly -- uninsured and underinsured patients unable to pay their medical bills. In order to protect themselves from the consequences of medical debt, patients need to be aware of alternatives. Yet HCRA's Indigent Care Pool requires nothing by way of patient notification or education. It provides no guidance regarding eligibility policies or application processes. HCRA requires only that hospitals implement minimum collection practices, and it prohibits patients sued by a hospital for unpaid bills from raising as a defense the fact that the hospital claimed the cost of his or her care when filing its annual Indigent Care Report with the state.<sup>22</sup>

In 2004, the Healthcare Association of New York State (HANYS) released "Financial Aid/Charity Care Guidelines," similar to those issued by the American Hospital Association. Surveys done subsequent to the HANYS guidelines indicate that while improvements have been made by some New York hospitals, policies vary widely from community to community, and within communities, from hospital to hospital.<sup>23</sup>

---

<sup>20</sup> New York State Comptroller's Office, "HCRA: The Need to Restore Accountability to State Taxpayers," Albany, NY (2003).

Available online at: <http://www.osc.state.ny.us/reports/health/hcra.pdf>.

<sup>21</sup> N.Y. Pub. Health L. § 2807-k(12) limits reporting to a) the hospital costs incurred and uncollected amounts a hospital claims it provided in bad debt and charity care; and b) costs incurred and uncollected amounts for deductibles and coinsurance for patients with insurance or other third party payer coverage. Patient specific information, even numbers of patients served, is not required.

<sup>22</sup> N.Y. Pub. Health L. Section 2807-k(9).

<sup>23</sup> See Footnote 23, *supra*.

## The Purpose and Scope of This Study

Several studies have collected information about hospital policies and practices regarding uncompensated care. The Legal Aid Society has surveyed hospitals in New York City on two separate occasions. Likewise, the Public Policy and Education Fund of Citizen Action New York has rated institutions across the state, at least once, and twice in several upstate cities.<sup>24</sup> These reports have been extremely useful in terms of furthering the discussion of New York's laws and policies regarding bad debt and charity care in hospital settings.

To date, however, no one has gathered data on the impact of unpaid health care bills from the New York consumer's perspective. Information about the group of people who are unable to access care without incurring significant debt is an important piece of the picture that our state policy makers need in order to agree upon a rational and consistent system for charity care in New York.

In addition, we believe that the data presented in this report will be instructive in confronting proposed cuts to New York's public health insurance programs. For example, efforts to impose additional co-payments on services or to reduce eligibility for Medicaid or Family Health Plus will simply lead to greater debt among low income consumers.

## Methodology

We surveyed consumers at bankruptcy clinics in Albany, Syracuse, Rochester and Buffalo because they represent a group of low-income people who have accumulated significant debt. We gathered information on demographics and insurance status, and asked respondents whether they had unpaid medical bills from any sources, including hospitals, doctors, pharmacies, and ambulance services. For those with significant unpaid medical bills, we asked about the consequences of this debt for themselves and their families.<sup>25</sup>

As with any voluntary research study, there are limitations that should be acknowledged before we present our findings. First, as

---

<sup>24</sup> Public Policy and Education Fund of New York, "Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?" September 2003; The Legal Aid Society, Health Law Unit, "State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Funds," 2003. For updated reports by the same agencies, see Public Policy and Education Fund of New York Reports on Hospital Financial Aid in the Capital District (November, 2004), Rochester (May, 2005), and Utica (June 2005); and The Legal Aid Society, Health Law Unit, "State Secret 2005," January 2005. For a detailed discussion of the wide variance in charity care policies in Rochester area hospitals, see, L.M. Sax, "Charity Care in Rochester," *Finger Lakes Health Systems Agency* (September 2005).

<sup>25</sup> For details on methodology, see Appendix A.

mentioned above, the survey was distributed to a restricted population, all of whom were low-income persons facing financial difficulties. Thus, the sample is not randomly selected and cannot be viewed as representative of the general population in upstate New York.

Second, the survey depends on respondents' accurate account of their debt and situation. There were no attempts made to ensure that respondents accurately completed the survey, unless there were blatant inconsistencies in answers. In such cases, if contact information was provided, we attempted to reach the respondents and clarify the responses. If clarification was not possible, the survey was excluded from our analysis.

Finally, since the staff at various bankruptcy clinics differed from region to region, we could not ensure consistency in survey presentation. It is likely that there were differences in the amount of detail provided to respondents regarding the purpose of the survey, as well as the level of encouragement and assistance offered to each participant in completing the survey.

We present the findings from our survey not as a statistically valid study, but as a snapshot of the circumstances currently confronting low-income New Yorkers struggling with medical debt. Even so, the details that emerge provide an important perspective on some of the health policy questions our elected officials are currently grappling with. We hope the results will inform the process.

# Key Findings

This section presents the key findings from our survey. A more detailed discussion of the methods used is presented in Appendix A. Data tables on the results of the survey are presented in Appendix B. The survey instrument is in Appendix C.

*86% of those with medical debt were either covered by health insurance intermittently or continuously throughout the 12 months prior to taking the survey.*

Over half of the people who sought help from bankruptcy clinics and responded to the survey were struggling with medical debt. In fact, the percentage of those with medical debt in the survey, 58%, is slightly higher than that documented in the recent national study conducted by Harvard.

African American respondents were absorbing a disproportionate share of medical debt, and women were more likely to find themselves unable to pay medical bills than the men in the survey.

The percentage of persons 64 and older who reported medical debt in our survey was significant, (41%), which should serve as a warning that in urban, upstate New York, even those with access to Medicare may have difficulty affording the health services they need.

Most significantly, the data indicate that medical debt is a serious problem in cities across upstate New York, for both those who are uninsured and those who are underinsured. Indeed, 86% of those with medical debt were either covered by health insurance intermittently or continuously throughout the 12 months prior to taking the survey.

One of the strongest indicators of medical debt that emerged from the study was insurance status. Here, somewhat surprisingly, the data showed that those experiencing a gap in coverage were three times as likely to incur medical debt as those who were completely uninsured.

Of those with medical debt, 62% owed less than \$5,000 while 27% owed more than \$10,000. Given that 90% of all respondents were living on incomes at or below \$25,000 this debt level is significant.

Eighty percent of all respondents with medical debt reported owing money to hospitals, which is consistent with the theory that medical debt is rarely entered into in a truly voluntary and informed manner due to the crisis atmosphere surrounding hospitalizations in particular.

We found that 74% of those with debt who had continuous health coverage had hospital debt; 78% of those with intermittent or some coverage had hospital debt and over 80% of those without any coverage during the previous 12 months had hospital debt.

Almost 60% of those in debt owed money to doctors. The driving force behind their medical debt was more likely to be an ongoing illness (40%). Almost one-third (32%) of those with medical debt said the source of the debt was paying for routine care.

When we looked at the interaction between the reason for medical debt and insurance status, we found that most debtors with continuous insurance coverage reported ongoing medical problems as the source of their debt, while new illnesses or injuries were cited most often by those who were completely uninsured.

*Over half of the respondents with medical debt had delayed getting at least one type of medical care that they needed (58%).*

Over half of the respondents with medical debt had delayed getting at least one type of medical care that they needed (58%). While only five percent said they delayed getting hospital care, 43% said they delayed visits to a doctor, 42% delayed dental care, and 31% reported delays in filling prescriptions.

Over 40% said the delays were a result of providers asking for cash up front or denying care because of unpaid bills.

A total of 62% of those respondents with medical debt reported that they were not offered any financial assistance to help avoid or meet their debt and 66% had been contacted by a collection agency.

The surveys demonstrate that medical debt is likely to affect not only an individual's future access to health care, but also their economic and social well being. A full 78% of those with medical debt reported at least one financial problem as a result of the debt; and 39% sought loans from friends and family.

# Detailed Findings

## *Demographics of the Respondents in General*

All of those responding to the survey were seeking help from a bankruptcy clinic, therefore, all had debt. Fifty-eight percent had medical debt. Almost 70% of all respondents were female; 31% were male. Ninety percent of all respondents had annual incomes of under \$25,000.

As seen in Table 1 (Appendix B), 49% of respondents were between the ages of 25 and 44 years old. Fifty-seven percent were unemployed; 43% were employed. Seventy-four percent had at least one child in the household; 13% had four or more children. While 11% were married, 25% were divorced and 43% were single.

In terms of race and ethnicity, 54% of respondents were White, 36% were Black and 5% were Hispanic.

Fifty-five percent had continuous health coverage throughout the previous twelve months, 33% had intermittent coverage and 12% spent the previous year without any health coverage.

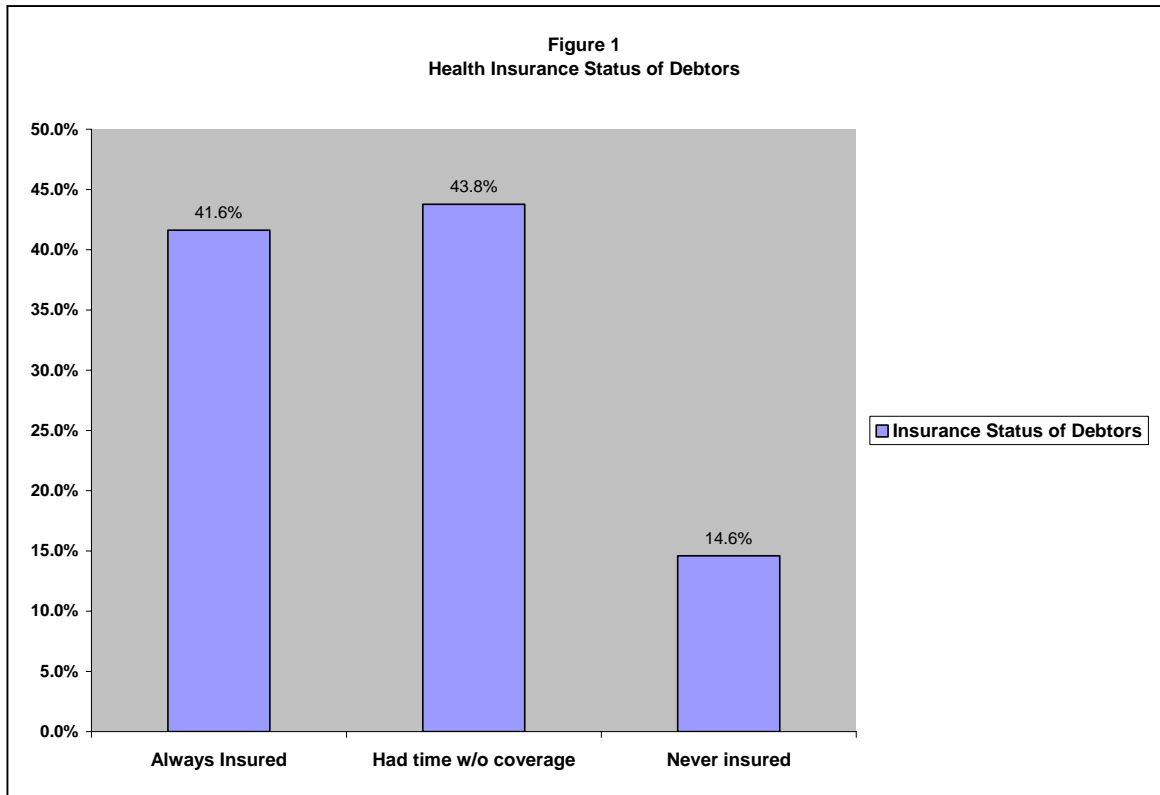
If there was a “typical” respondent, she was a white, single mother between the ages of 25 and 54 years old raising more than one child on an income of less than \$25,000 a year with some level of health insurance during the previous year and some level of medical debt.

## *Respondents with medical debt compared to those without*

We found that 58% of the respondents had medical debt. The data presented several interesting differences when looking at those with medical debt and when comparing those with medical debt to those without medical debt. (Tables 2 and 3, Appendix B).

Medical debt was more commonly associated with incomplete coverage, or gaps in coverage, than it was with a complete lack of insurance. Somewhat surprisingly, continuous coverage was also more prevalent among our respondents with medical debt than a complete lack of insurance. As Figure 1 illustrates, of the respondents with medical debt:

- ❑ 44% reported a time without insurance coverage.
- ❑ 42% reported continuous insurance coverage.
- ❑ Less than a fifth reported being completely uninsured (15%).



Significantly, almost 86% of those with medical debt either had some coverage or were continuously covered during the previous twelve months. Clearly the level and type of coverage one has is critical, with co-pays, deductibles and other out-of-pocket expenses leading to medical debt even for those with health coverage.

Looking further at those with medical debt when compared to those without medical debt, we found that:

- ❑ 66% of African American respondents had medical debt while 52% of White respondents and 56% of Hispanic respondents had medical debt.
- ❑ 52% of those with annual incomes of \$10,000 or less had medical debt, while over 64% of those with incomes between \$10,000 and \$25,000 and 75% of those with incomes between \$35,000 and \$50,000 annually had medical debt.
- ❑ 55% of all respondents had continuous health insurance in the 12 months prior to taking the survey, while less than 42% of those with medical debt had continuous coverage.
- ❑ 60% of women respondents and 55% of men respondents had medical debt.

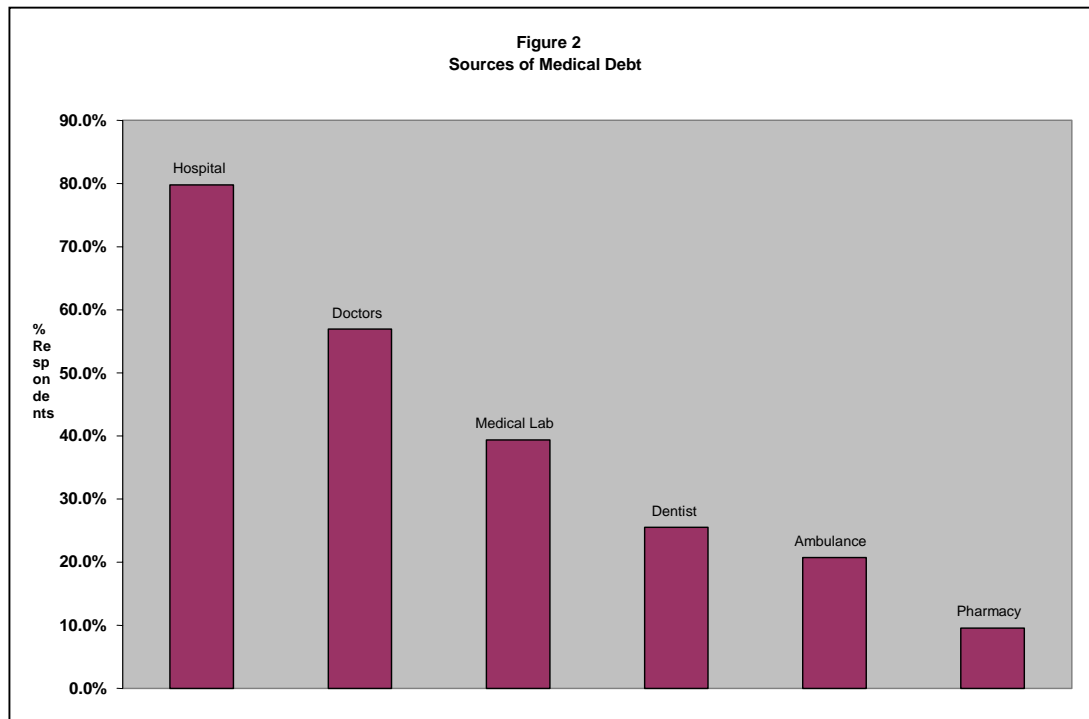
- ❑ Young people (ages 18-24) were significantly more likely to report medical debt than those respondents 64 years of age or older (69% v. 41%).
- ❑ 12% of all respondents had no health insurance in the previous 12 months while 15% of those with medical debt were completely uninsured.

In other respects, the profile for medical debtors roughly matches that of the respondents generally. Over 90% had annual incomes of less than \$25,000, roughly three-quarters had children and most (88%) were not married.

### *Amount, Sources and Reasons for Medical Debt*

Almost 25% of those with medical debt who responded to the survey did not specify the amount of their medical debt. Of those who did provide an amount, most (62%) owed less than \$5,000 to medical providers at the time they completed the survey. Over one quarter (27%) had more than \$10,000 in medical debt. (Table 4, Appendix B).

The data on the reason for medical debt indicate that medical debtors were more than twice as likely to incur debt from illnesses and new injuries as they were from routine care (78% v. 32%).



Again, given the low incomes of all respondents, a medical debt of \$5,000 can pose a significant burden on the household.

Many respondents with medical debt told us that their medical bills were generated from more than one source. As Figure 2 illustrates, 80% of those with medical debt said hospital bills were at least one source of their debt.

A significant percentage of medical debtors also reported owing money to doctors (57%). The next most common source of debt was medical labs (39%), followed by dentists (26%) and ambulance companies (21%). Only 10% of those with medical debt reported owing money to pharmacists. Most respondents with medical debt were not offered financial assistance in any form from their medical provider (62%). (Table 4, Appendix B).

### *Insurance Coverage*

We asked survey respondents to characterize their insurance status over the previous 12 months by choosing one of three responses: always covered, had a time without insurance, never covered. When we looked at insurance coverage in relation to other characteristics of survey respondents, we found several interesting associations. (Table 5, Appendix B).

- ❑ African Americans were less likely than whites to have continuous insurance coverage (50% v. 58%) and more likely to be completely uninsured (14% v. 10%) or experience gaps in coverage (36% v. 32%).
- ❑ Women survey respondents were more likely than men to have insurance coverage, at least some of the time. Men were almost twice as likely as women to be completely uninsured (17% v 9%).
- ❑ 85% of all respondents with incomes at or under \$10,000 had intermittent or continuous coverage; while 90% of respondents with incomes between \$10,000 and \$25,000 had some or continuous coverage throughout the preceding year
- ❑ Survey respondents who were employed were more likely to have experienced gaps in insurance coverage than those who were unemployed (35.6% v. 32%).

## Medical Debt and Insurance Status

When we looked at the interaction between the reason for medical debt and insurance status, we found that most debtors with continuous insurance coverage reported ongoing medical problems as the source of their debt, while new illnesses or injuries were cited most often by those who were completely uninsured. (Table 6, Appendix B).

As Figure 3 indicates, 52% of those with medical debt who had no insurance were facing medical debt due to a new illness or injury while 43% of those who were always covered, faced medical debt driven by an on-going illness.

In looking at sources of medical debt by coverage status, we found that 74% of those with debt who had continuous health coverage had hospital debt; 78% of those with intermittent or some coverage had hospital debt and over 80% of those without any coverage during the previous 12 months had hospital debt.

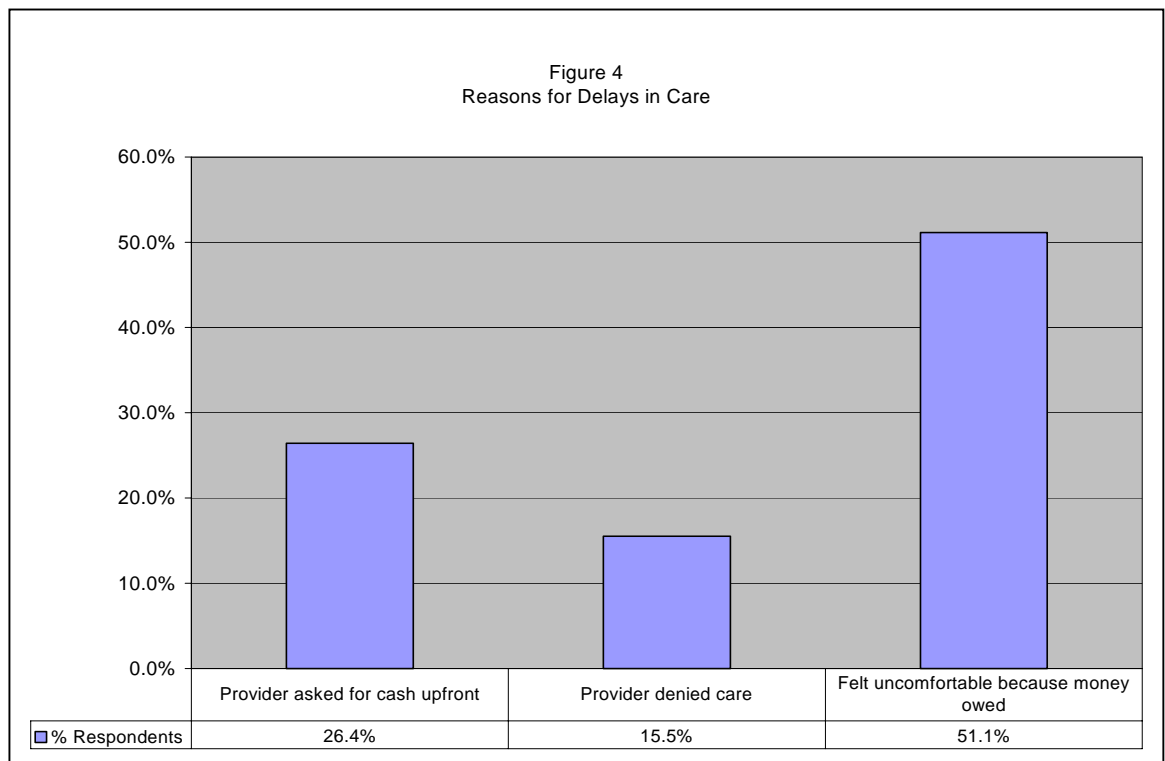


## Consequences of Medical Debt

Many of the respondents with medical debt indicated that they had experienced more than one of the potential consequences of medical debt identified in the survey. (Table 7, Appendix B).

**Delays in Accessing Care.** We found that over half of the respondents with medical debt had delayed getting at least one type of medical care that they needed (58%). While only five percent said they delayed getting hospital care, 43% said they delayed visits to a doctor, 42% delayed dental care, and 31% reported delays in filling prescriptions.

Many of the respondents with medical debt told us they delayed care because they felt uncomfortable owing money to health care providers. As Figure 4 illustrates, 51% of respondents with medical debt gave us this response. Over a quarter reported that they delayed care because providers asked for cash up front (27%), and 16% -- over one in six respondents -- said delays resulted from providers denying them care.



*In trying to address their medical bills, respondents were more than twice as likely to seek financial support from friends and family as to apply for a bank loan or use a credit card (18% v. 6% and 8%).*

**Financial Struggle.** We asked respondents with medical debt about the strategies they used to make ends meet and pay their medical bills, presenting choices reflecting traditional means of dealing with financial shortfalls (savings, credit cards, bank loans, mortgage/home equity funds, financial support or loans from family or friends). (Table 8, Appendix B).

The most common financial strategy medical debtors used to make ends meet was seeking loans or financial support from family or friends (39%). Likewise, in trying to address their medical bills, respondents were more than twice as likely to seek financial support from friends and family as to apply for a bank loan or use a credit card (18% v. 6% and 8%). A majority of respondents reported that owing money for medical bills made it harder for them to get loans or credit (62%).

**Housing Problems.** More than one-half (53%) of the respondents with medical debt reported that owing money for medical bills had contributed to at least one housing problem. (Table 9, Appendix).

The most frequently reported problems were as follows:

- 36% reported that medical debt contributed to difficulty with rent or mortgage payments
- 24% reported that medical debt contributed to being denied a rental unit or mortgage
- 12% reported that medical debt contributed to being forced to move
- 9% reported that medical debt had resulted in a lien being filed against their home

**Employment Problems.** More than one-third (36%) of the respondents with medical debt experienced a loss of income associated with illness or injury. In addition, many respondents reported that medical debt contributed to a serious problem at work:

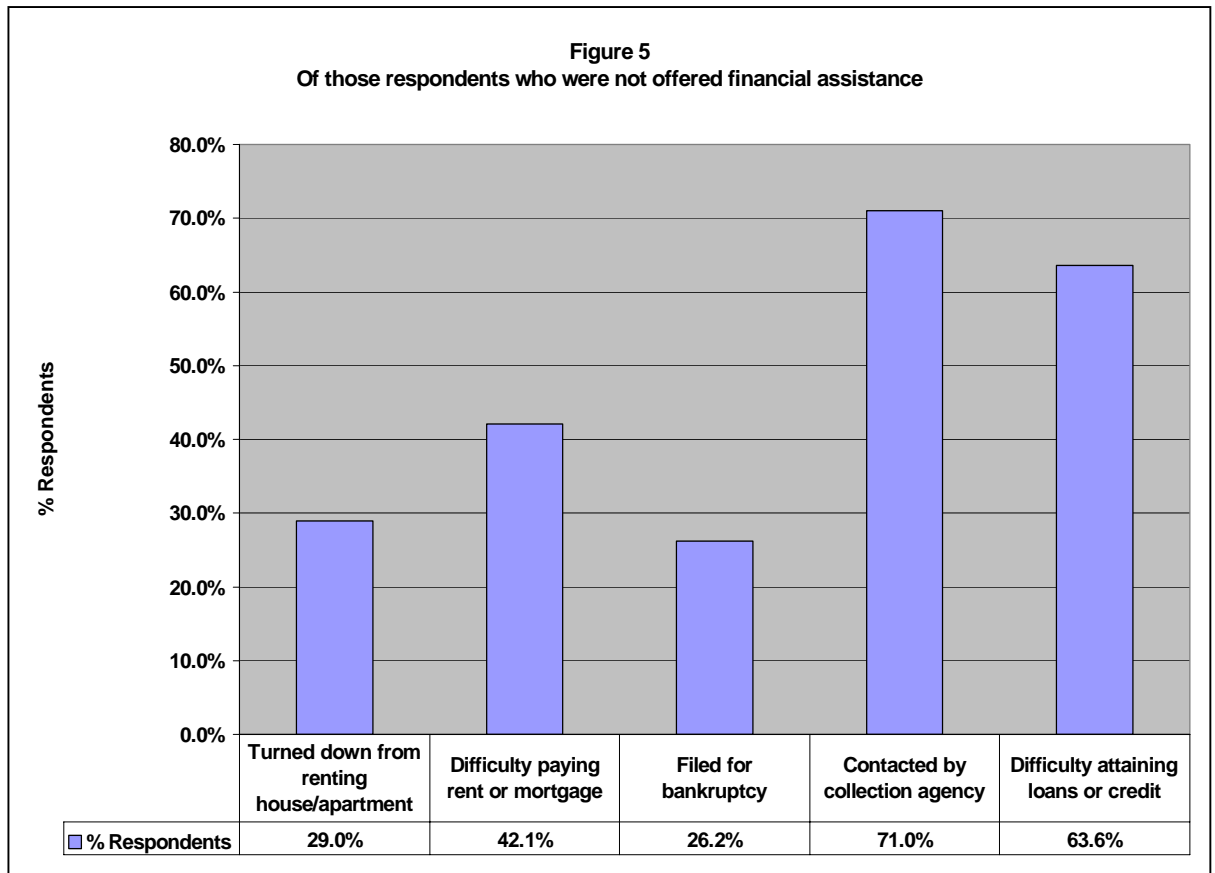
- 21% said they were denied a job due to poor credit
- 13% said medical debt contributed to increased work hours
- 9% said medical debt contributed to wages being withheld

**Provider Response to Unpaid Bills.** Two-thirds of medical debtors were contacted by collection agencies; 14% reported being sued for the money they owed. Less than 40% of respondents with medical debt reported receiving any kind of financial assistance from their provider.

## Lack of Financial Assistance

A total of 62% of those respondents with medical debt reported that they were not offered any financial assistance to meet their debts. As noted earlier, 80% of those with medical debt had hospital debt. When we looked more closely at the medical debtors who did not receive any financial assistance from their providers, we found that this is a group likely to experience multiple financial problems.

As Figure 5 illustrates, over 70% were being pursued by collection agencies and over 60% had difficulty obtaining loans or credit. More than 40% of this group also reported difficulty paying rent, and almost 30% were turned down by landlords when seeking a rental. (Table 10, Appendix B).



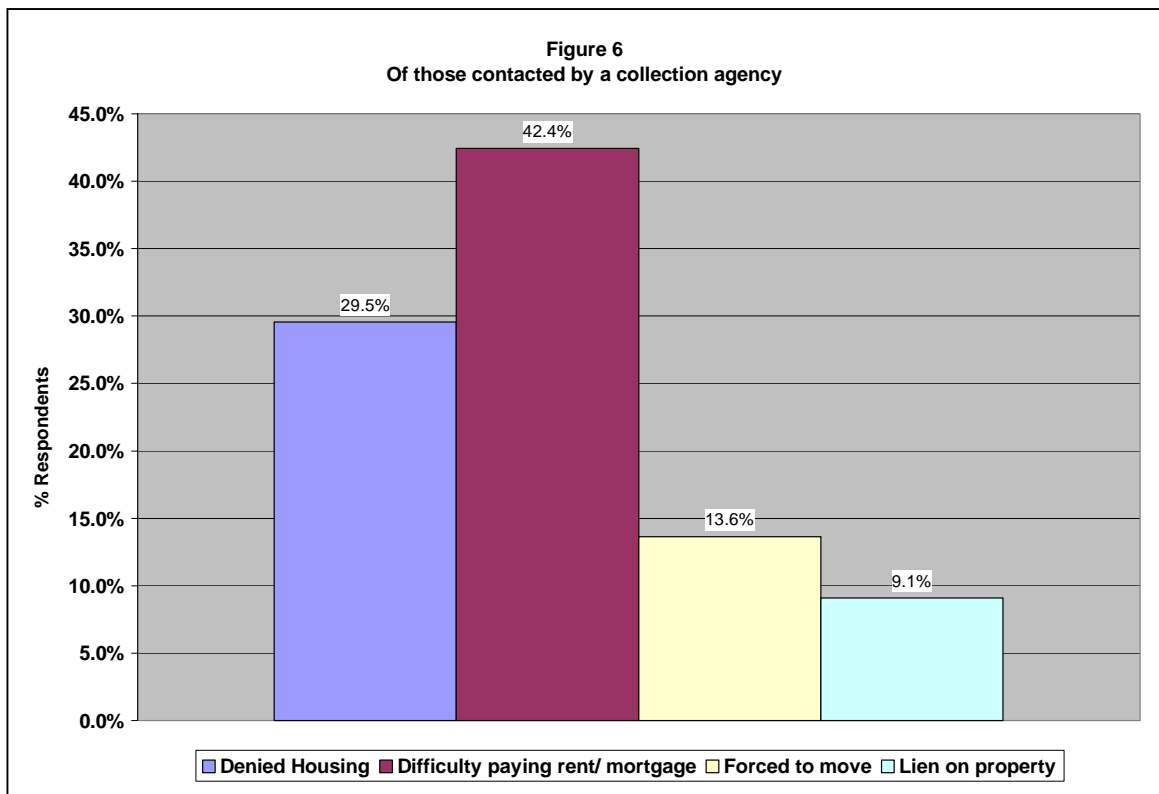
**Problems Compounded Generally.** Not surprisingly, we found significant overlap generally between problems with financial issues, housing and employment.

Almost half of those who filed for bankruptcy had trouble paying their rent or mortgage, and almost one-third was denied housing. (Table 11, Appendix B)

As Figure 6 illustrates,

Of those contacted by collection agencies:

- ❑ More than 40% had difficulty paying rent;
- ❑ Almost 30% reported being denied housing;
- ❑ 14% were forced to move and
- ❑ Close to one in ten had a lien placed on their property (9%).



Similarly, 71% of the respondents who reported having their wages withheld because of medical debt also had difficulty paying their rent or mortgage. One-third of those who were forced to move were denied employment due to bad credit. (Table 12, Appendix).

The data clearly indicate that medical debt impacts individuals and families, not just in the area of health care, but in housing, employment and financial issues as well.

# Discussion

As noted earlier, this survey was intended to provide a snapshot of medical debt in urban communities in upstate New York, and cannot be expected to illustrate trends or dynamics over time. Nonetheless, the picture that emerges from the data provides insight into the nature and consequences of medical debt in New York.

## *The Size of the Problem*

A threshold question we sought to answer in conducting the survey was: “How large is the problem in upstate communities?” On this issue, the answer is clear. Medical debt is a substantial problem in urban, upstate New York. Well over half of the people who sought help from bankruptcy clinics and responded to the survey are struggling with medical debt. In fact, the percentage of those with medical debt in the survey is slightly higher than that documented in the recent national study conducted by Harvard.<sup>26</sup>

The data on strategies used to address medical debt and make ends meet suggests that the ripple effect of medical debt casts an even larger shadow. The most common strategy that medical debtors reported using to pay medical bills and/or make ends meet was seeking financial help from families and friends. Almost 40% of medical debtors turned to their support networks of family and friends. Requests such as these from family members or friends are likely to put significant psychological, and ultimately, financial pressure on the larger social and familial networks.

The data on problems with housing and employment add to the sense that a serious ripple effect is likely.

## *The Source of the Debt*

The data on the source and reason for medical debt presents us with a picture of low-income families confronting a large pile of bills after one or more hospitalizations. Eighty percent of the respondents with medical debt reported owing money to hospitals, which is consistent with the theory that medical debt is rarely entered into in a truly voluntary and informed manner due to the crisis atmosphere surrounding hospitalizations in particular.<sup>27</sup> The

---

<sup>26</sup> D. Himmelstein et al., “Illness and Injury as Contributors to Bankruptcy,” *Health Affairs* (Web Exclusive. Site, W5-66).

<sup>27</sup> R. Seifert, “The Demand Side of Financial Exploitation: The Case of Medical Debt,” *Housing Policy Debate*, 13:3:785-803 (2004).

## Forgiveness From Hospital, Owes Surgeons

P.J. is a 55-year old man who experienced serious heart problems while caring for his terminally ill life-companion in their home. He was unemployed and uninsured at the time. P.J. underwent heart surgery prior to his companion's death and was re-hospitalized for congestive heart failure shortly after her death. Despite regular payments toward more than \$70,000 of past due bills, the hospital turned his account over to a collection firm, which sued him and froze his checking account. Ultimately, with legal assistance, P.J. was able to access the hospital's charity care program. However, he is now being sued for almost \$8,000 by the surgical practice that performed his heart surgery. He also still owes money for ambulance and laboratory services.

fact that less than 40% of the respondents reported receiving any offer of assistance with their bills from their provider is a clear indication that low-income patients need better notice and education regarding the availability of hospital charity care.

A significant percentage (57%) of respondents also reported owing money to doctors. This finding is particularly noteworthy, given the fact that hospital charity care policies do not extend to surgical groups or doctors who provided medical care during a hospitalization.

Somewhat surprisingly, relatively few medical debtors attributed their debt to pharmacies. At first blush, this finding might seem contrary to the very high pharmaceutical expenses faced by the uninsured or underinsured. However, it might be explained by the fact that, unlike other medical providers, pharmacists do not generally provide their service, prescription drugs, without receiving payment up front. Those consumers who know that they cannot pay on the spot for their prescriptions may simply forgo their medications. This explanation is consistent with our findings regarding access to care – over 30% of those who said that they delayed seeking medical care because of medical debt identified prescription drugs as a service they went without, at least temporarily.

Another potential explanation for the fact that fewer respondents reported owing money to pharmacists is that those dependent on pharmaceutical services may go to great lengths to pay for their medications, even at the risk of letting other bills go unpaid.

### *Who is Medical Debt Most Likely to Hit?*

Not unexpectedly, the data illustrates that the African American community in urban upstate New York is absorbing a disproportionate share of medical debt, and that women are more likely to find themselves unable to pay medical bills than are men. This finding is consistent with recent research on racial disparities in access to health care, as well as health outcomes.<sup>28</sup> The fact that Latinos fail to emerge as a group shouldering a disproportionate share of medical debt is likely attributable to the fact that very few Hispanic clients returned the survey. In fact, the

---

<sup>28</sup> Thirty-nine percent of women had problems with medical bills in the Commonwealth study, compared to 24 percent of men. Over 50% of working age African Americans reported such difficulties, in contrast to 34% of Hispanics and 28% of Whites. M. Doty, et al, "Seeing Red: Americans Driven into Debt by Medical Bills," *The Commonwealth Fund*, August 2005. For outcome disparity studies, see, e.g. "Effects of race, insurance status, and hospital volume on perforated appendicitis in children," by Dr. Smink, Steven J. Fishman, M.D., Ken Kleinman, Sc.D., and Jonathan A. Finkelstein, M.D., M.P.H., in the April 2005 *Pediatrics* 115(4), pp. 920-925; "Technology diffusion, hospital variation, and racial disparities among elderly Medicare beneficiaries 1989-2000," by Dr. Groeneveld, Sara B. Laufer, M.A., and Alan M. Garber, M.D., Ph.D., in the April 2005 *Medical Care* 43(4), pp. 320-329; "Determinants of JNC VI guideline adherence, intensity of drug therapy, and blood pressure control by race and ethnicity," by Dr. Hicks, David G. Fairchild, Mark S. Horng, and others in the October 2004 *Hypertension* 44, pp. 429-434.

## Pharmacy Bills Paid; Others Pile Up

E.B. is a 77-year-old woman living on social security and a small retirement pension. Her health is not good. She suffers from an inflammatory lung disease, high blood pressure, hypertension, thyroid problems and a benign tumor in her intestinal region. She takes 18 pills a day. Although retiree benefits pay for 80% of her prescription costs, the remaining 20% comes to around \$500 a month. Because an interruption in her medications would be life threatening, she pays the \$500 every month. After paying her mortgage, she is then left with \$66 every month to somehow cover her utility bills, telephone bills and groceries. While she has not incurred medical debt, her other bills have accumulated and she is now \$10,000 in debt. A lien has been placed on her home and she receives phone calls every other day from collection agencies, adding to her stress and anxiety.

bankruptcy clinics have had difficulty reaching out to Latino clients. Language and cultural barriers likely play a large role.

The percentage of persons 64 and older who reported medical debt in our survey was significant, (41%), which should serve as a warning that in urban, upstate New York, even those with access to Medicare may have difficulty affording the health services they need. The even higher percentage of persons between the ages of 18 and 24 (68.8%) with debt is consistent with studies that find young people among the most likely to report difficulty paying medical bills.<sup>29</sup>

The findings regarding income level and employment would appear to bear out the success of public insurance programs in preventing medical debt among the very low income. The study finds the struggle with medical debt occurring most often just above the federal poverty level (FPL), in households that tend to be employed almost as often as they are unemployed.

### *Gaps in Coverage Drive Debt*

One of the strongest indicators of medical debt that emerged from our study was insurance status. Here, somewhat surprisingly, the data showed that those experiencing a gap in coverage were three times as likely to incur medical debt as those who were completely uninsured. According to the survey, employment doesn't necessarily shield people from lapses in insurance coverage, since those with gaps were almost as likely to be employed as unemployed.

The fact that a smaller group of medical debtors in the survey were completely uninsured might be explained by the fact that people who are accustomed to being uninsured have developed strategies for getting health care services, such as bartering with community members or visiting free clinics. Those who are continuously uninsured may also be a healthier population, which is consistent with our finding that the source of debt for those continuously uninsured is more likely to be a new illness or injury than an ongoing medical condition.

The fact that a very large percentage of those with medical debt experienced gaps in coverage is particularly alarming when viewed in light of the difficulty many low-income New Yorkers have maintaining coverage through public health insurance programs, even when they are in fact eligible for these programs.

---

<sup>29</sup> M. Doty, et al, "Seeing Red: Americans Driven into Debt by Medical Bills," *The Commonwealth Fund*, August 2005

## **Difficulty Maintaining Coverage**

R.B. is a disabled mother of two who receives Social Security Disability. Her family was covered by Medicaid until recently, when R.B. finally found temporary employment. Because her wages put the family just over the limit for Medicaid, R.B. applied for Child Health Plus for her children. Her first application was denied, and before she received approval on the second application, her son broke his arm and had to receive medical care. She is now unemployed again, and faced with thousands of dollars in medical bills.

## **Loss Of Income, High Co-Pays, Heavy Debt**

O.N. is the mother of two children. She was 35 years old and working at a credit union when she suffered a stroke. Her husband's insurance covered the emergency care she needed, but her health only worsened in the following years. She went through two kidney transplant operations and was diagnosed with diabetes, glaucoma and high blood pressure. She must take nearly 30 pills every day. While Social Security Disability Income helped somewhat, her husband's private insurance policy required significant co-payments for doctor visits and medications, and the family of four was unable to make ends meet. O.N.'s husband has filed for divorce and O.N. faces an insurmountable level of debt.

## ***Underinsurance and Medical Debt***

Over 40% of medical debtors in the survey actually had continuous insurance. This large group fits the definition of "underinsured" – people with some insurance coverage, whose out-of-pocket expenses exceed their ability to pay. The picture that emerges from the survey of a large group of underinsured low-income people struggling with high out of pocket costs is consistent with previous research funded by the Kaiser Family Foundation. The KFF documented a large group of Americans with private insurance who nonetheless were exposed to very high out of pocket costs relative to their incomes.<sup>30</sup>

As the authors of the Kaiser research point out, large numbers of underinsured Americans should serve as a warning against reliance on barebones insurances policies, particularly for low-income individuals and families. The survey's documentation of large numbers of underinsured people in urban, upstate New York underscores the inherent problems with imposing significant cost-sharing requirements and services restrictions in programs such as Medicaid, Family Health Plus and Child Health Plus. Low-income individuals and families are ill-equipped to pay for uncovered services or contribute more in co-payments. If forced to do so, they will inevitably join the ranks of the underinsured, and either accrue medical debt or do without care or both.

## ***The Impact of Medical Debt***

While demographic data gives us some sense of the size and contour of the footprint medical debt leaves, it is only through exploration of the consequences of medical debt that we get a sense of the nature of the experience. The survey makes it clear that many families with medical debt experience devastating consequences.

The data is consistent with other studies documenting difficulty in accessing care for those struggling with medical debt.<sup>31</sup> Over half of the medical debtors surveyed reported delays in accessing care. Over half of these respondents initiated the delay themselves, due to feeling uncomfortable because they owed money. However, over 40% said the delays were a result of providers asking for cash up front or denying care because of unpaid bills.

---

<sup>30</sup> C. Hoffman, et al, "Medical Debt and Access to Health Care," Kaiser Family Foundation, Sept. 2005. Available online at: <http://www.kff.org/uninsured/7403.cfm>. See also, C. Schoen, et al, "Insured But Not Protected: How Many Adults Are Underinsured?" Health Affairs (2005 Web Exclusive: W5):289-302.

<sup>31</sup> Seeing Red: Americans Driven into Debt by Medical Bills, Michelle M. Doty, Ph.D., Jennifer N. Edwards, Dr.P.H., and Alyssa L. Holmgren, The Commonwealth Fund, August 2005.

## Going Without Care

L.B. is a 40-year-old security guard in the Albany area with no health insurance. Several years ago L.B. suffered a heart attack and needed emergency care. Neither the hospital nor the doctor's office that provided subsequent care offered him any financial assistance with what amounted to almost \$12,000 in medical bills. Three months later collection agencies were calling. Fearful of incurring further debt, L.B. refrained from seeing any more doctors and went without prescription drugs for his heart condition. Although he has filed for bankruptcy and will soon be free of debt, L.B. has yet to visit a doctor or begin purchasing medications.

Very few medical debtors reported delaying hospital care due to debt, as opposed to other services. Two factors likely come into play here. First, those seeking hospital care are often responding to critical emergencies or life-threatening circumstances. Second, many people are aware that hospitals have an obligation to provide emergency services, even to those unable to pay. Unfortunately, the tendency to fall back on accessing care through hospitals not only leads to worsening health status, it compounds the underlying debt. Follow-up interviews with survey respondents emphasized the shock people experience in learning of the high costs they are responsible for following emergency hospitalizations.

The majority of medical debtors reported that they did not use any of the strategies traditionally utilized by those struggling to pay off debt and still make ends meet (bank loans, home equity, credit cards). Given the low-incomes of the respondents, it is unlikely that many had access to significant home equity. It may be that the debtors did not have a credit card or that credit cards were less appealing as a means to address a large debt suddenly incurred after a hospitalization, as opposed to debts that grow incrementally, like purchases of clothing or appliances. The loss of income associated with injury or illness, combined with the existing debt may also make it unrealistic for the respondents to apply for a bank loan.

As discussed earlier, the most common strategy for addressing medical debt and making ends meet was seeking financial help from family and friends. The stress this places on extended social networks, as well as debtors, is significant. Two-thirds of those with debt were also being pursued by collection agencies as a result of their medical debt.

Many of the respondents with medical debt experienced a double whammy – for over one-third the hospitalization that results in the pile of bills is accompanied by a loss of income due to the illness or injury. Our data further indicate that the debt itself can make the transition to other employment extremely difficult. Over 20% of the respondents reporting employment problems said they had been denied a job due to poor credit. This response raises significant questions regarding hiring practices and would benefit from further study.

Medical debt also puts people at increased risk of losing stable housing. A national report on medical debt and housing problems found that over 25% of low and middle-income people with medical debt experienced housing problems, including ability to qualify for a mortgage or make mortgage or rent payments. Even for those with less than \$500 in medical debt, 12% reported that bad credit reports contributed to housing problems.<sup>32</sup>

---

<sup>32</sup> "Home Sick," *The Access Project*, November 2005.

## **Snowballing Consequences**

D.N. is a divorced father of three living in the Rochester area. Several years ago he fell behind on child support payments during a period of temporary unemployment. After finding a new job with an auto dealership, he spent most of his wages trying to catch up with child support and couldn't afford the health insurance plan offered by his employer. Then, he suffered a heart attack and underwent emergency bypass surgery, which left him with more than \$50,000 in medical bills. He increased his work hours to begin payments on the bills but his account was turned over to collection agencies. Eventually, his bank accounts were frozen and his wages garnished. David's health has improved, but he is unemployed, with a credit history that has thwarted his job search. He has a lien on his home and faces the possibility of losing it.

The data indicate that housing problems are common among low-income upstate New Yorkers with medical debt. Over half of the respondents with medical debt in the survey reported that owing money for medical bills contributed to a serious housing problem. Over 35% reported difficulty making rent or mortgage payments. Almost 12% were forced to move.

The likelihood of experiencing difficulties related to housing was heightened still further for those respondents with medical debt in the survey who either failed to receive financial assistance from their providers, or were contacted by collection agencies. Over 40% of each of these groups had difficulty paying rent. One in eight of those contacted by a collection agency were forced to move, and almost 30% of those contacted by collection agencies were denied rentals because of their debt.

In sum, the survey data highlight medical debt as a common phenomenon among low-income families in upstate, urban New York. Medical debt is rarely planned for and generally involuntary in nature. The financial problems associated with medical debt often snowball, relentlessly gathering speed as dependence on hospital services grows and medical conditions worsen, putting income and housing at risk. Clearly, medical debt can be enough to tip the scales for many families in urban upstate New York, sending them over the edge, from financial independence to financial disaster.

# Recommendations

The policy recommendations growing out of this survey on medical debt are twofold.

1. First and foremost, we recommend that New York maintain, and work to increase, public health insurance coverage for low income people unable to access affordable employer-based coverage.

Clearly, both consumers and providers are better off with comprehensive health insurance. Uninsured and underinsured consumers are at risk of high medical debt, delayed health care and increased financial stress. Hospitals cannot afford to rely upon partial, retroactive reimbursement for ever-larger portions of their services.

However, hospitals also owe it to the public to provide a clearer accounting of their use of the public funds currently available for bad debt and charity care. And while hospital bills are the most common source of medical debt, our research shows that many low-income families in upstate New York also owe money to other health care providers. These health care providers also suffer when their patients lack adequate health insurance coverage and are ultimately unable to pay for services.

The Legislature must resist proposals to narrow coverage and increase cost sharing in Medicaid, Family Health Plus and Child Health Plus. Indeed, these programs should be expanded, not curtailed. The data in this report illustrate why it is essential that New York fight the current trend of passing more of the financial burden of health care to individuals through higher co-payments and pared down coverage.

Barebones insurance policies must not be portrayed as encouraging prudent use of health care; low-income individuals and families simply cannot afford the same kind of out of pocket contributions to health care as middle and upper-income families. If we are to shield low-income families from medical debt and protect their often-fragile hold on financial independence, public insurance programs must provide adequate financial protection relative to income.

It is also crucial that New York investigate strategies for maximizing enrollment in its public health insurance programs. Families and individuals that are actually eligible for Medicaid or Family Health Plus should not be subject to the financial stress of Medical Debt. Whenever possible, our public programs should operate to keep people healthy and lower the rising costs associated with uncompensated hospital care.

2. Given the high levels of hospital debt and the low-level of provider assistance with unaffordable bills, we urge implementation of uniform charity care requirements for New York's hospitals and investigation of similar programs for other medical providers.

Uniform charity care policies and procedures in New York's hospitals would allow patients to be more informed and better understand the steps they need to follow in order to access free and low-cost care.

More specifically:

- Hospitals should be required to report the number of uninsured or underinsured patients they serve each year, the number of patients who are denied charity care, and to explain the hospital's annual charity care costs.
- Hospitals should implement clear and consistent eligibility standards and procedures for consumers seeking financial assistance through the hospital's charity care.
- Hospitals should work to screen patients for potential eligibility for on-going coverage through any public or private coverage they may qualify for – without constructing or imposing barriers to care.
- All hospitals should be required to notify patients about how to access charity care funds whenever bills are sent.
- Hospitals should not be allowed to sue patients eligible for charity care who have followed appropriate application procedures and should be required to develop special collection policies for low-income households with medical debt.
- Better auditing and reporting should be established to link charity care funding to direct patient care and reward hospitals that serve larger numbers of uninsured and underinsured patients.

To address these concerns we urge passage of the package of bills currently being carried by Assembly Insurance Committee Chairman Pete Grannis and Assembly Health Committee Chairman Richard Gottfried (A. 2519, A. 2520, A. 2521). As of this printing, Senator George Maziarz has introduced a companion bill to A.2519 which would require hospitals to disclose information of their use of charity care funds (S.4347).

Governor George Pataki has also recognized the problems and has proposed legislation that would require hospitals to establish financial assistance policies, which may include charge reductions or sliding fee scale payments, for individuals earning less than 200% of poverty. While the governors' proposal is not as

comprehensive as the Assembly bills, it indicates his recognition that the program is in need of reform.

The state should also review and where appropriate revise its approach to reimbursing hospitals for the care they provide to those unable to pay. There should be a rational and equitable approach to hospital reimbursement for bad debt and charity care.

Charity care policies should cover primary care for the uninsured and underinsured as well. Health clinics with standardized sliding scales and prescription plans must be supported and encouraged. Access to affordable primary care and necessary medications will prevent subsequent presentations of more serious and more expensive illnesses at hospital emergency rooms.

In addition, other types of providers, such as surgical groups, doctors' offices, medical labs, dentists and ambulance services, have not been examined on this issue to the same extent as hospitals. Further scrutiny may yield strategies and standards for combating debts in these areas as well.

Finally, it must be noted, that the true solution to so many of these problems is the creation of a universal health care system.

# Appendix A

## METHODOLOGY

We adapted a survey initially employed by the Access Project in Massachusetts. A copy of the survey we used is attached as Appendix C.

In order to distribute the survey, we partnered with four bankruptcy clinics in upstate New York: The Volunteer Legal Services Project in Rochester, Legal Services of Central New York in Syracuse, The Legal Project in Albany and the Volunteer Lawyers Project in Buffalo. Each of these clinics is facilitated by a legal services office or a pro bono organization; each strives to provide information and counseling services at no charge to low-income families and individuals in serious financial difficulty. Each of the clinics offers general informational sessions on a regular basis throughout the calendar year, followed up by more individualized or small group counseling. The clinics are able to offer legal representation to only a small fraction of those who attend the initial informational sessions.

Our surveys were distributed to all consumers attending the initial informational sessions at the clinics during the period from August of 2004 through September of 2005. Participation in the survey was voluntary and anonymous. In total, 348 individuals responded to our survey.

The respondents were initially divided into two groups for analysis according to the response to the first question: "Do you owe money for medical bills?" After having categorized those who were in debt and those who were not, we asked all respondents demographic-related questions in order to get an image of what the average medical debtor may look like compared to other consumers with financial difficulties.

Following a question regarding the consumer's health insurance status, the next series of questions attempted to glean information about those with medical debt: how they met their expenses and the problems they confront as a result of their debt. We asked questions regarding the sources of and reasons for their medical debt, the ease of access to charity care or financial assistance for medical expenses, methods used to pay for medical bills as well as making other ends meet, the effects of their debt on employment, housing, finances, and lastly whether their indebtedness affected further access to medical care.

At the end of the survey, respondents were encouraged to participate in a follow-up interview by phone; about 62% of respondents reporting to have medical debt agreed to such interviews. Some of these were contacted and interviews were used in the personal narratives that are used throughout this report.

## Appendix A

As with any voluntary research study, there are limitations that should be acknowledged. Since the survey was distributed at a limited forum (of financially disadvantaged consumers) and respondents participated voluntarily, our sample is not randomly selected. It may not represent data regarding all consumers and cannot be generalized for such a purpose.

Also, the survey depends on the respondents' accurate account of their debt situation. We made no attempts to ensure that respondents accurately completed the survey unless there were blatant inconsistencies in answers. In such cases, if contact information was provided, we attempted to reach the respondent and verify their responses. If we were unable to verify responses, the survey was excluded our analysis.

Finally, it should be acknowledged that the clinic staff administering the survey differed in each city. We expect that there was some variance in both the amount of detail offered to respondents regarding the purpose of the survey and the level of assistance provided in answering it.

## Appendix B

### Demographics of ALL Respondents

TABLE 1

Demographics of ALL Respondents			
TABLE 1			
<b>Total Respondents</b>	<b>348</b>		
<b><u>Gender</u></b>		<b><u>Employment Status</u></b>	
Male	30.9%	Employed	43.4%
Female	69.1%	Unemployed	56.6%
<b><u>Age</u></b>		<b><u>Children</u></b>	
18-24	4.6%	0	26.0%
25-34	22.3%	1	22.1%
35-44	26.3%	2	20.6%
45-54	25.7%	3	18.8%
55-64	12.7%	4	6.9%
Over 64	8.4%	More than 4	5.7%
<b><u>Marital Status</u></b>		<b><u>Race</u></b>	
Married	11.2%	White	53.8%
Divorced	25.1%	Black	35.8%
Widowed	7.2%	Native American	1.2%
Single	42.7%	Asian	0.3%
Separated	13.8%	Hispanic	4.6%
		Other	4.3%
<b><u>Income</u></b>		<b><u>Insurance Status</u></b>	
\$10,000 less	49.1%	Always covered	54.8%
\$10,000 - \$24,000	41.3%	Had lapses	33.4%
\$25,000 - \$34,999	8.4%	Never insured	11.8%
\$35,000 - \$49,999	1.2%		
\$50,000 or greater	0.0%		

# Appendix B

## Demographics of Respondents with Medical Debt

Includes Only Respondents with Medical Debt

**TABLE 2**

<b>Total Surveys Collected</b>	<b>348</b>		
<b>Number with Medical Debt</b>	<b>200</b>		
<b>% In Debt</b>	<b>57.5%</b>		
<b><u>Those with Medical Debt</u></b>		<b><u>Insurance Status</u></b>	
Male-Female Ratio	3:7	Always Insured	41.6%
Employed	44%	Had time w/o coverage	43.8%
Caucasian-minority Ratio	1:1	Never insured	14.6%
% below 25K income	90.0%		
<b><u>Age</u></b>		<b><u>Children</u></b>	
18-24	5.6%	0	24.9%
25-34	22.7%	1	20.7%
35-44	28.8%	2	21.8%
45-54	26.8%	3	18.7%
55-64	10.1%	4	7.8%
Over 64	6.1%	More than 4	6.2%
<b><u>Effects of Debt</u></b>		<b><u>Marital Status</u></b>	
Bankruptcy	28.0%	Married	11.0%
Collection Agencies	66.0%	Divorced	28.0%
Lawsuit	14.0%	Widowed	7.5%
		Single	42.5%
		Separated	11.0%

## Appendix B

### Comparison of Respondents With and Without Medical Debt

Includes ALL Respondents

**TABLE 3**

	<i>% Who Had...</i>				<i>% Who Had...</i>		
	<i>Medical Debt</i>	<i>No Medical Debt</i>	<i>Total N</i>		<i>Medical Debt</i>	<i>No Medical Debt</i>	<i>Total N</i>
<b><u>Gender</u></b>				<b><u>Insurance Status</u></b>			
Men*	54.7%	45.3%	106	Always Insured	44.7%	55.2%	172
Women	59.5%	40.5%	237	Had time w/o coverage	77.1%	22.8%	105
			343	Never Insured	73.0%	27.0%	37
% Female**	70.9%	66.7%					
<b><u>Race/Ethnicity</u></b>				<b><u>Employment Status</u></b>			
White	52.2%	47.8%	186	Employed	58.8%	41.2%	148
Black	66.1%	33.9%	124	Unemployed	56.5%	43.5%	193
Hispanic	56.3%	43.8%	16				341
Other	57.1%	42.9%	21	% Unemployed**	55.6%	57.9%	
Non-white	64.0%	36.0%	161				
% Minority**	51.5%	39.5%		<b><u>Income</u></b>			
				Less than \$10,000	52.4%	47.6%	164
				\$10,000 - \$24,999	64.5%	35.5%	138
				\$25,000 - \$34,999	57.1%	42.9%	28
				\$35,000 - \$49,999	75.0%	25.0%	4
				\$50,000 or more	0.0%	0.0%	0
							334
				% less than \$25,000**	90.2%	90.7%	
<b><u>Children</u></b>				<b><u>Marital Status</u></b>			
0	55.2%	44.8%	87	Married	56.4%	43.6%	39
1	54.1%	45.9%	74	Divorced	64.4%	35.6%	87
2	60.9%	39.1%	69				
3	57.1%	42.9%	63	Widowed	58.3%	41.7%	24
4	65.2%	34.8%	23	Single	57.4%	42.6%	148
More than 4	63.2%	36.8%	19	Separated	45.8%	54.2%	48
			335				346
% with children**	75.1%	72.5%		% not married**	88.9%	88.4%	
<b><u>Age</u></b>				*This shows the percentage of men in our sample who fall into each category of debt. For example, 54.7% of our total male respondents to have medical debt.			
18-24	68.8%	31.3%	16	**This statistic shows the percentage of respondents in each debt category who are in this demographic. For example, 70.9% of all respondents to have medical debt were female.			
25-34	58.4%	41.6%	77				
35-44	62.6%	37.4%	91				
45-54	59.6%	40.4%	89				
55-64	45.5%	54.5%	44				
Over 64	41.4%	58.6%	29				
			346				

## Appendix B

### Level and Source of Medical Debt Among Respondents

Includes Only Respondents with Medical Debt  
TABLE 4

<u>Level of Medical Debt</u>	<u>% Respondents</u>
\$0-\$5,000	61.6%
\$5,001 - \$10,000	11.3%
Over \$10,000	27.2%
 <u>Source of Debt</u>	
Hospital	79.8%
Doctors	56.9%
Medical Lab	39.4%
Dentist	25.5%
Ambulance	20.7%
Pharmacy	9.6%
 <u>Reason for Debt</u>	
Ongoing Illness	40.3%
New Illness / Injury	38.1%
Routine Care	32.4%
 No Financial Assistance Offered	 61.8%

# Appendix B

## Comparison by Status of Health Insurance Coverage

Includes ALL Respondents

**TABLE 5**

	<i>% Who...</i>				<i>% Who...</i>		
	<i>Were Always Covered</i>	<i>Had Time w/o Insurance</i>	<i>Never Had Insurance</i>		<i>Were Always Covered</i>	<i>Had Time w/o Insurance</i>	<i>Never Had Insurance</i>
<b><u>Gender</u></b>				<b><u>Employment Status</u></b>			
Male*	52.0%	30.6%	17.3%	Employed	55.3%	35.6%	9.1%
Female	55.7%	34.9%	9.4%	Unemployed	54.5%	32.0%	13.5%
% Female**	69.8%	71.2%	54.1%	% Unemployed**	57.1%	54.8%	66.7%
<b><u>Race/Ethnicity</u></b>				<b><u>Income</u></b>			
White	58.4%	31.8%	9.8%	Less than \$10,000	53.9%	31.6%	14.5%
Black	50.0%	36.4%	13.6%	\$10,000 - \$24,999	49.6%	40.0%	10.4%
Hispanic	53.8%	38.5%	7.7%	\$25,000 - \$34,999	84.0%	12.0%	4.0%
Other	47.1%	29.4%	23.5%	\$35,000 - \$49,999	50.0%	50.0%	0.0%
Non-white	50.0%	35.7%	14.3%	\$50,000 or more	-	-	-
% Minority**	40.9%	47.6%	54.1%	% less than \$25,000**	86.1%	95.1%	97.2%
<b><u>Children</u></b>				<b><u>Marital Status</u></b>			
0	51.9%	35.4%	12.7%	Married	50.0%	47.2%	2.8%
1	66.2%	22.1%	11.8%	Divorced	50.6%	28.6%	20.8%
2	50.8%	40.0%	9.2%	Widowed	60.0%	35.0%	5.0%
3	54.4%	31.6%	14.0%	Single	54.3%	34.8%	10.9%
4	33.3%	55.6%	11.1%	Separated	64.3%	26.2%	9.5%
More than 4	58.8%	29.4%	11.8%	% not married**	89.5%	83.7%	97.3%
% with children**	75.3%	72.5%	72.2%				
<b><u>Age</u></b>							
18-24	43.8%	43.8%	12.5%				
25-34	55.4%	33.8%	10.8%				
35-44	56.8%	34.6%	8.6%				
45-54	55.8%	29.9%	14.3%				
55-64	37.5%	42.5%	20.0%				
Over 64	79.2%	16.7%	4.2%				

*\*This shows the percentage of men in our sample who fall into each category of insurance coverage. For example, 52% of our total male respondents reported always having coverage. .*

*\*\*This statistic shows the percentage of respondents in each insurance category who are in this demographic. For example, 69.8% of all respondents who reported to have always had coverage were female.*

## Appendix B

### Medical Debt Sources by Status of Health Insurance

Includes Only Respondents with Medical Debt

**TABLE 6**

<u>Sources of Medical Debt</u>	<i><u>Always Covered</u></i>	<i><u>Had Time w/o Insurance</u></i>	<i><u>Never Had Insurance</u></i>
Hospital	74.0%	77.8%	81.5%
Doctor	53.2%	60.5%	51.9%
Dentist	19.5%	22.2%	37.0%
Pharmacy	9.1%	8.6%	3.7%
Medical Lab	27.3%	44.4%	51.9%
Ambulance	13.0%	24.7%	29.6%
Other	6.5%	6.2%	3.7%
 <b><u>Reasons for Debt</u></b>			
New Illness or Injury	32.4%	41.1%	52.0%
On-going Illness	42.6%	41.1%	28.0%
Routine Health Care	33.8%	32.9%	24.0%
Birth	5.9%	6.8%	8.0%
Other	25.0%	20.5%	24.0%

# Appendix B

## Delays in Needed Care for Respondents with Medical Debt

Includes Only Respondents in Medical Debt  
TABLE 7

<u>Delayed These Due to Medical Bills</u>	<u>% Respondents</u>
Doctor Visit	43.1%
Dental Visit	41.9%
Filling a prescription	31.3%
Hospital Stay	5.0%
No Delay	41.9%
Delay in at least one type of care	58.1%

## Reasons for Delay in Doctor Visits for Respondents in Debt

Includes Only Respondents in Medical Debt

<u>Delayed Doctor Visits Because:</u>	<u>% Respondents</u>
Provider asked for cash upfront	26.4%
Provider denied care	15.5%
Felt uncomfortable because of money owed	51.1%
No delay in care	41.4%

# Appendix B

## How Respondents in Debt Tried to Pay Their Medical Bills

Includes Only Respondents with Medical Debt  
**TABLE 8**

<u>Strategies:</u>	<u>% Respondents</u>
Bank Loan	6.3%
Refinance/second mortgage	2.5%
Loan from family/friends	18.2%
Charged payment to credit card	8.2%
None of the above	66.0%
Other	11.3%

## How Respondents in Debt Tried to Make Ends Meet

Includes Only Respondents in Medical Debt

<u>Strategies:</u>	<u>% Respondents</u>
Savings	18.6%
Credit Cards	17.4%
Financial support from family/friends	38.9%
Mortgage/home equity borrowing	4.2%
Other	3.0%
None of the above	45.5%

## Appendix B

### Housing, Employment and Financial Problems

Includes Only Respondents in Medical Debt

TABLE 9

<b><u>Housing Problems</u></b>	<b><u>% Respondents</u></b>
Turned down from renting house/apartment	23.5%
Difficulty paying rent or mortgage	35.9%
Forced to move	11.9%
Lien placed on property	8.5%
Other	1.5%
Noted at least one housing problem	52.5%
<b><u>Employment Problems</u></b>	
Wages withheld	8.5%
Increased work hours	12.5%
Denied job due to poor credit	20.5%
Other	2.0%
Noted at least one employment problem	36.5%
<b><u>Financial Problems</u></b>	
Filed for bankruptcy	27.5%
Contacted by collection agency	66.0%
Difficulty attaining loans or credit	61.5%
Noted at least one financial problem	77.5%

# Appendix B

## Financial Assistance

Includes Only Respondents in Medical Debt

TABLE 10

Of Those Who Were NOT Offered Financial Assistance...

<u>Housing Problems</u>	<u>% Respondents</u>
Turned down from renting house/apartment	29.0%
Difficulty paying rent or mortgage	42.1%
Forced to move	13.1%
Lien placed on property	10.3%
<u>Employment Problems</u>	
Wages withheld	12.1%
Increased work hours	14.0%
Denied job due to poor credit	21.5%
<u>Financial Problems</u>	
Filed for bankruptcy	26.2%
Contacted by collection agency	71.0%
Difficulty attaining loans or credit	63.6%
<u>Delays in Care</u>	
Doctor Visit	31.8%
Hospital Stay	3.7%
Filling a prescription	22.4%
Dental Visit	35.5%
No Delay	39.3%
<u>Reasons For Delay In Care</u>	
Provider asked for cash upfront	26.2%
Provider denied care	15.0%
Felt uncomfortable because of money owed	44.9%
No Delay in care	41.1%

## Appendix B

### Financial Problems by Housing Problems

Includes Only Respondents with Medical Debt

**TABLE 11**

*Of those with x employment problem... % with y housing problem*

	<b>Housing Problems</b>					<i>Total Respondents</i>
	<i>Denied Housing</i>	<i>Difficulty Paying Rent/ Mortgage</i>	<i>Forced To Move</i>	<i>Lien on Property</i>	<i>Other</i>	
<b>Financial Problems</b>						
<i>Filed for Bankruptcy</i>	32.7%	45.5%	12.7%	10.9%	3.6%	55
<i>Contacted by Collection Agency</i>	29.5%	42.4%	13.6%	9.1%	2.3%	132
<i>Difficulty Attaining Loans or Credit</i>	31.7%	48.0%	13.8%	11.4%	2.4%	123

### Housing Problems by Financial Problems

Includes Only Respondents with Medical Debt

*Of those with x housing problem... % with y employment problem*

	<b>Financial Problems</b>			<i>Total Respondents</i>
	<i>Filed for Bankruptcy</i>	<i>Contacted by Collection Agency</i>	<i>Difficulty Attaining Loans or Credit</i>	
<b>Housing Problems</b>				
<i>Denied Housing</i>	38.3%	83.0%	83.0%	47
<i>Difficulty paying rent/ mortgage</i>	33.8%	75.7%	79.7%	74
<i>Forced to move</i>	29.2%	70.8%	75.0%	24
<i>Lien on property</i>	35.3%	82.4%	70.6%	17
<i>Other</i>	66.7%	100%	100%	3

# Appendix B

<b>Employment Problems by Housing Problems</b>						
Includes Only Respondents with Medical Debt						
TABLE 12						
<i>Of those with x employment problem... % with y housing problem</i>						
<b>Employment Problems</b>	<b>Housing Problems</b>					<u>Total Respondents</u>
	<u>Denied Housing</u>	<u>Difficulty Paying Rent/ Mortgage</u>	<u>Forced To Move</u>	<u>Lien on Property</u>	<u>Other</u>	
<i>Wages withheld</i>	29.4%	70.6%	0.0%	17.6%	0.0%	17
<i>Increased work hours</i>	32.0%	64.0%	8.0%	12.0%	0.0%	25
<i>Denied job due to poor credit</i>	34.1%	46.3%	19.5%	12.2%	2.4%	41
<i>Other</i>	0.0%	75.0%	75.0%	25.0%	25.0%	4
<b>Housing Problems by Employment Problems</b>						
Includes Only Respondents with Medical Debt						
<i>Of those with x housing problem... % with y employment problem</i>						
<b>Housing Problems</b>	<b>Employment Problems</b>				<u>Total Respondents</u>	
	<u>Wages Withheld</u>	<u>Increased Work Hours</u>	<u>Denied Job Due to Poor Credit</u>	<u>Other</u>		
<i>Denied Housing</i>	10.6%	17.0%	29.8%	0.0%	47	
<i>Difficulty paying rent/ mortgage</i>	16.2%	21.6%	25.7%	4.1%	74	
<i>Forced to move</i>	0.0%	12.5%	33.3%	12.5%	24	
<i>Lien on property</i>	17.6%	17.6%	29.4%	5.9%	17	
<i>Other</i>	0.0%	0.0%	33.3%	33.3%	3	

# Appendix C

## Survey Questionnaire on Medical Debt

Thank you for taking the time to complete this survey. Your answers will be kept completely confidential. If you do not wish to participate, please say so. Your decision to participate or not will not affect the quality of service you receive.

### A. MEDICAL DEBT

1. Please specify the date and location on which you completed this survey, and the program staff that provided or assisted you with the survey:

Date & Location: \_\_\_\_\_

Program Staff: \_\_\_\_\_

2. Do you, or any immediate family member, owe money for medical bills?

No If NO, please complete SECTION B ONLY.

Yes If YES, please complete the ENTIRE SURVEY.

### B. ABOUT YOU AND YOUR HOUSEHOLD

Your answers to the following questions will help us be sure we have included a wide variety of people in our survey.

3. What is your gender?  Male  Female

4. What is your age?

18-24  25-34  35-44  45-54  55-64  over 64

5. What is your marital status?

Married  Divorced  Widowed  Single  Separated

6. What is your household size?

1  2  3  4  5  More than 5

7. How many children do you have?

0  1  2  3  4  More than 4

8. Are you currently  Employed  Unemployed

9. What is your race/ethnicity (check all that apply)?

White  Black  Native American  Asian  Hispanic  Other

10. If you recently immigrated to the United States, please specify your country of origin:

\_\_\_\_\_

11. Which best describes your household's annual income from all sources?

Less than \$10,000  \$25,000 - \$34,999  \$50,000 or more

\$10,000 - \$24,000  \$35,000 - \$49,999

**12. During the last 12 months, did you have health insurance ALL the time, or was there a time during the year when you DID NOT have any health coverage?**

- Health Insurance all the time/Always covered
- Had a time without insurance
- Uninsured all the time/Never covered

Health Insurance includes Medicaid, Family Health Plus, Child Health Plus, & Healthy New York, as well as private insurance plans.

**C. ABOUT YOUR MEDICAL BILLS**

Your answers to the following questions will help us understand how your medical bills came about.

**13. Where are your medical bills from (check all that apply)?**

- Hospital (please specify name & location) \_\_\_\_\_
- Doctor     Dentist     Pharmacy/Drug Store
- Medical Laboratory     Ambulance Service     Other \_\_\_\_\_

**14. Which best describes the reason you, or a family member, owe money for medical bills (check all that apply)?**

- A new illness/injury     An illness/injury that has been on-going for a long time
- A birth of a child     Routine health care, such as pediatric or dental care
- Other (describe) \_\_\_\_\_

**15. Did the doctor's office, hospital, or other provider where you owe money offer any of the following assistance?**

- Offer to discount the bill     Inform you about free care     Suggest a payment plan
- Inform you about public assistance     Suggest you take out a loan to help pay for your bill
- Offer you a special credit card     No assistance offered
- Other (describe) \_\_\_\_\_

**15a. If a payment plan was offered, was it helpful in reducing your medical bills?**

- Yes     No

Please explain \_\_\_\_\_

**16. Have you tried any of the following strategies to pay your medical bills?**

- Bank loan     Mortgage Refinance or second mortgage
- Personal loan from friends or family     Charged payments to a credit card
- No, I have not used any of the above to pay my medical bills.
- Other (please describe) \_\_\_\_\_

17. Please estimate about how much you owe in connection with medical bills, either to medical providers, credit card companies, or loan agencies: \$ \_\_\_\_\_

17a. Has the amount you owed increased because of interest or fees?  
\_\_\_\_\_

17b. Is this debt related to one injury/illness or multiple episodes?  
\_\_\_\_\_

**D. YOUR QUALITY OF LIFE**

In this section we would like to know if your medical bills contributed to any housing or employment problems.

18. Has owing money for medical bills contributed to any of the following **housing problems** for you or a household member?

- a. Turned down from renting a house or apartment     Yes     No     Not Applicable
- b. Difficulty paying rent or mortgage                     Yes     No     Not Applicable
- c. Forced to move     Yes     No     Not Applicable
- d. A lien placed on my property                             Yes     No     Not Applicable
- e. Other (please describe) \_\_\_\_\_

19. Has owing money for medical bills contributed to any of the following **employment problems** for you or a household member?

- a. Wages withheld     Yes     No     Not Applicable
- b. Increased work hours                                         Yes     No     Not Applicable
- c. Denied job because of poor credit                     Yes     No     Not Applicable
- d. Filed for bankruptcy                                         Yes     No     Not Applicable
- e. Other (please describe) \_\_\_\_\_

**E. YOUR HEALTH CARE**

Your answers to questions in this section will help us to understand how owing money for medical bills affects the health care that you and other members of your household receive.

20. Since owing money for medical bills, have you, or an immediate family member, needed but delayed getting any of the following health care (check all that apply)?

- Doctor visit                     A hospital stay                     Filling a prescription/drugs
  - Dental visit                     No, I have not delayed getting health care
  - Other (describe) \_\_\_\_\_
- \_\_\_\_\_

**21. Since owing money for medical bills, have you, or a family member, delayed going to see the doctor for any of the following reasons (check all that apply)?**

- Provider(s) asked you or a household member to pay cash upfront
- Provider(s) denied care to you or a family member because you owe them money
- I feel uncomfortable because I owe money
- No, I have not delayed getting health care
- Other (describe) \_\_\_\_\_

**22. Since owing money for medical bills, have you had to use any of the following to make ends meet?**

- Savings       Credit Cards       Financial support from friends and family
- Mortgage or home equity borrowing       No, I have not used any of the above to make ends meet
- Other (describe) \_\_\_\_\_

**23. Has owing money for medical bills made it harder to get loans or credit?**  Yes  No

**23a. If Yes, HOW did it make it harder (check all that apply)?**

*I or a family member:*

- Was denied a credit card       Was denied a loan
- Other (describe) \_\_\_\_\_

**24. Because of the money you owe for medical bills, have you or a family member:**

- a. Been sued in court?       No       Yes (*Who sued you?*) \_\_\_\_\_
- b. Been contacted by a collection agency?       No       Yes (*For what bill?*) \_\_\_\_\_

**25. Did your illness or injury result in reduced income?**

- Yes (please explain) \_\_\_\_\_
- No

**26. Please feel free to tell us any further information about your experience with medical debt:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**27. Would you be willing to participate in a follow-up interview? If so, please provide the following information so we may contact you:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Thank you for taking the time to complete this survey.  
Your answers will be kept completely confidential.**

**Program Staff: Please return  
completed surveys to:**

**Trilby de Jung  
The Greater Upstate Law Project, Inc.\*  
80 St. Paul Street, Suite 660  
Rochester, NY 14604  
Phone: 1-800-724-0490 x 08  
Fax: 585-454-2518**

- 
- Now the Empire Justice Center, One West Main St, Suite 200, Rochester, NY 14614