

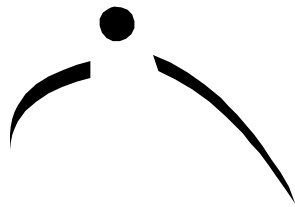
# PLAYING BY THE RULES BUT LOSING

How Medical Debt Threatens Kansans'  
Healthcare Access and Financial Security

By: Carol Pryor, The Access Project  
Jeffrey Prottas, Brandeis University

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**The Access Project** (TAP) has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. TAP's fiscal sponsor is Third Sector New England, a non-profit with more than 40 years of experience in public and community health projects. TAP is affiliated with the Heller School for Social Policy and Management at Brandeis University.



The Access Project  
89 South Street, Suite 404  
Boston, MA 02111  
(617) 654-9911  
Fax: (617) 654-9922  
[www.accessproject.org](http://www.accessproject.org)

# Contents

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Executive Summary..... 1

Introduction.....6

Methodology.....9

Findings.....10

Discussion.....19

Recommendations.....23

Conclusion.....27

Endnotes.....28

Acknowledgements.....30



# Executive Summary

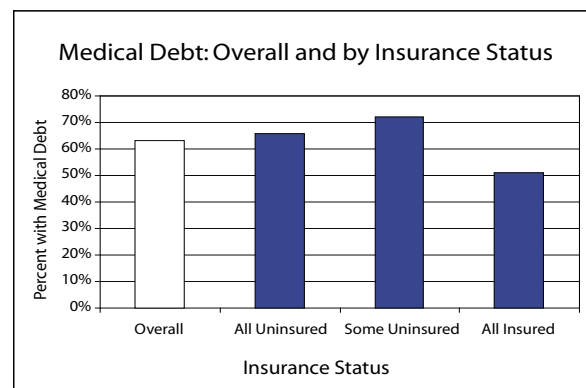
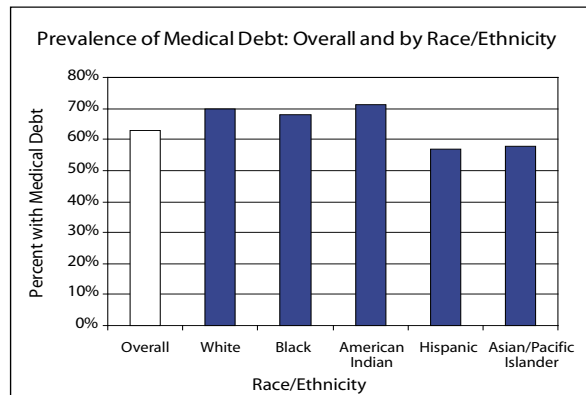
Recent research has shown that large numbers of Americans face unaffordable medical bills and resulting medical debt. National studies have documented that 25 to 40 percent of the population face medical bill problems, with lower income people and the chronically ill most at risk. These problems are not limited to the uninsured. In one study of those with medical bill problems, more than 6 in 10 had insurance coverage.

The consequences of medical debt can be serious and far reaching. Most directly, those with medical debt experience diminished access to care. However, many are also afflicted with a host of financial problems that can undermine their and their families' economic security. These include being unable to pay for basic necessities; using up all of their savings to pay for medical care; being denied employment; and being turned down from mortgages or renting homes because of damaged credit.

This study investigates both the extent and the consequences of medical debt among low-income Kansans. It reports on findings of a survey conducted between May and August of 2005 with 1,058 patients at four community health centers in Kansas—two in Wichita, one in Emporia, and one in Garden City. The survey examined respondents' medical debt from all sources, including hospitals, doctors, dentists, prescription medications, and ambulance services.

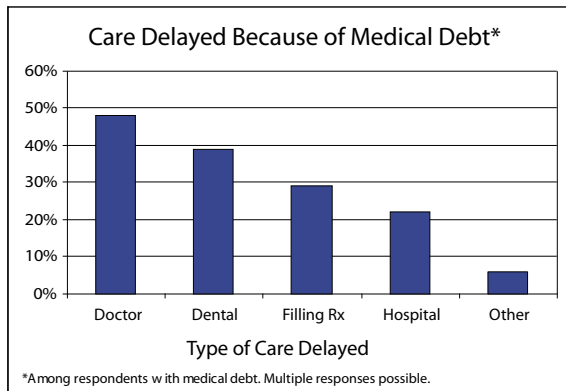
## KEY FINDINGS

**Medical debt was widespread among survey respondents. It affected majorities of all racial and ethnic groups, as well as those with and without insurance.** Nearly two-thirds (63%) of survey respondents reported currently owing money for medical bills. Over half of all racial and ethnic groups reported current medical debt, with immigrants having somewhat lower rates than those born in the United States (43% vs. 57%). Among those in families where all or some people were uninsured, rates ranged between 66 and 72 percent. Even in families where everyone had been insured for the previous year, over half (51%) reported having medical debt.



**Many with medical debt were never informed about the availability of financial assistance by their providers.** Among respondents with medical debt, almost 4 in 10 (39%) reported never receiving offers of financial assistance from their medical providers. Among those offered help, the most common form was a payment plan. Only 14 percent of those with medical debt said their bills had been discounted.

**Medical debt significantly diminished people’s access to medical care.** Nearly half (48%) of those with medical debt said they had delayed a doctor’s visit because of the debt, while nearly 4 in 10 (39%) delayed a dental visit.



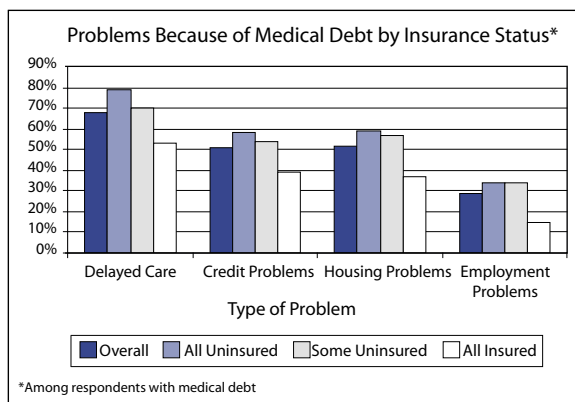
Of those who delayed care over half said they delayed care out of embarrassment (59%), while almost two-thirds (63%) said they did not want to add to existing debt. One out of six respondents who delayed care said they were refused an appointment because of the debt. Over a quarter of those with medical debt (26%) changed primary care doctors because of money they owed for care.

**People with medical debt struggled to pay their bills.** More than 4 in 10 respondents (41%) with medical debt borrowed money from friends or family to pay their bills, while 2 in 10 (20%) used a large portion of their savings to pay them. Others put bills on their credit cards, took out loans, or borrowed against their homes.

**Medical debt often resulted in credit, housing, and employment problems.** Over half of those with medical debt (51%) said the debt made it harder for them to get loans and access credit. More than half (52%) said the debt contributed to housing problems, including making it harder to pay the rent or mortgage, being turned down from renting a house or apartment, being unable to get a mortgage, or being forced to move. Almost three in 10 (29%) said the debt contributed to employment problems, such as having to increase work hours, having wages withheld, or being denied a job because of poor credit.

**Medical debt caused reduced access to care and had damaging financial consequences for significant portions of the insured as well as the uninsured.** Large portions of those with medical debt in households where all or some family members were uninsured delayed care because of the debt (79% and 70% respectively). However, over half (53%) of those in households where everyone was insured also reported delaying care. Similarly, while over half of those with medical debt in households where some or all family members were uninsured experienced

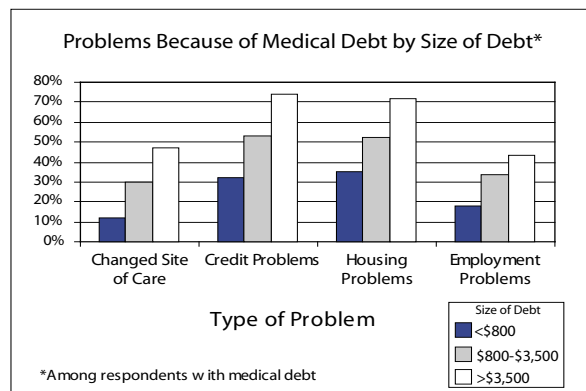
problems getting loans or credit, nearly 4 in 10 (39%) of those in families where everyone was insured also experienced these problems. And, while over half (approximately 57%) of those with medical debt in households where some or all family members were uninsured experienced housing problems because of the debt, these problems affected more than a third (37%) of those in families where everyone was insured as well.



“  
**The health insurance is too high. I haven’t had a check-up since my daughter was born four years ago.**”

*-Wichita mother of 4 who owes \$500*

**Problems related to medical debt resulted from relatively small amounts of debt. The likelihood of these problems increased dramatically with even relatively small increases in the amount of debt.** For example, housing problems affected over a third (35%) of respondents with medical debt under \$800. This percentage rose to over half (52%) of those with debts between \$800 and \$3,500, and to almost three-quarters (72%) of those with debts over \$3,500. Similar patterns were observed with respect to the impact of the size of debt on the likelihood of people changing their site of care and experiencing credit and employment problems.



## RECOMMENDATIONS

The findings of this study reinforce national research on the prevalence and consequences of medical debt; they indicate that significant portions of low-income Kansans have medical debt and experience the cascading access and financial problems that follow in its wake. The findings also contradict some commonly held notions: that people can always get health care if they need it, even if they can't pay for it, and that many patients have the resources but simply refuse to pay for care. In addition, the findings call into question current policy approaches that advocate increased cost-sharing by consumers as a way to restrain health care costs, and the provision of less expensive "bare bones" insurance policies to make insurance more affordable. Rather than "frivolously" seeking inappropriate services, many respondents in the study are already forgoing needed care because of the costs, and even those with relatively small debts—well below the deductibles proposed for many "bare bones" health insurance plans—suffered high levels of housing, employment, and credit problems.

The following recommendations suggest some approaches that could help reduce the prevalence of this debt or alleviate its consequences.

**Maintain and expand public insurance programs such as Medicaid and HealthWave.** Enrolling low-income people in public insurance programs has the potential to reduce medical debt among this population. It may also create overall savings by giving people access to treatment before their conditions become more expensive to treat.

**Maintain and expand the capacity of safety-net facilities.** Safety-net facilities provide affordable care for people of limited means. Funding these facilities may also be cost-effective. Research in Kansas has shown that the availability of safety-net clinics reduces hospital emergency room visits by the uninsured and increases the use of preventative services, which may result in savings later on.

**Improve health care providers' policies related to billing, collection, and screening for eligibility in public or private financial assistance programs.** A significant percentage of respondents with medical debt in this study were never told about the availability of financial assistance programs. This suggests that hospitals and other health care providers could help reduce medical debt and potentially enhance their revenues by doing better screening of patients for eligibility for public programs, such as

Medicaid and HealthWave. In addition, they could implement and publicize charity care programs that provide access to care for those without the resources to pay. For those who do not qualify for these programs, providers should offer significant discounts and reasonable payment plans tailored to people's actual ability to pay.

**Consider restricting the reporting of medical debt to credit agencies.** This study shows high rates of problems accessing credit due to medical debt. Other studies have linked the appearance of medical debt on credit reports with an increased likelihood of experiencing housing problems. Given the involuntary nature of medical debt and the potential problems that may result when it appears on credit records, policy makers might want to further investigate and consider whether health care providers should be allowed to report medical debts to credit-reporting agencies.

**Provide financial counseling to patients facing unaffordable medical expenses.** Organizations that provide financial counseling to lower income people could work with their clients with medical debt to help them investigate the availability of financial assistance options and/or negotiate discounts and manageable payment plans with providers. They could also discourage their clients from pursuing risky strategies for paying off their debt, such as taking out high interest payday loans or borrowing against their homes, which could undermine their financial stability in the long run.

**Ensure that health insurance coverage provides policy holders with access to care and protection from financial ruin.** The high rates of medical debt among insured respondents in this study call into question the adequacy of many insurance products. More attention needs to be paid to the design of health insurance policies to ensure that policy holders are not exposed to potentially ruinous levels of financial risk. Possible approaches include setting standards for adequate coverage and limiting cost-sharing obligations based on policy holders' incomes.

“  
**Medical debt has left me owing money and ruined my credit. It took my full savings.... All my preparation did not cover the costs of an emergency.**”

*-Female college student from Wichita who owes \$540*

# Introduction

In the last few years, the high prevalence of medical debt—that is money owed for medical services or products—has been extensively documented, both at the national level and within particular communities. The research has shown that the consequences of medical debt include not just reduced access to care, but also a wide range of financial problems that often burden families for years. The purpose of this study is to investigate both the extent and the consequences of medical debt among low-income Kansans. It reports on findings from a survey conducted with patients at four community health centers in Kansas—two in Wichita, one in Emporia, and one in Garden City. The survey examined respondents’ medical debt from all sources, including hospitals, doctors, dentists, prescription medications, and ambulance services.

## BACKGROUND

### *Prevalence of Medical Debt*

A national survey conducted by The Commonwealth Fund found that, in 2003, two of five Americans (41%) had medical bill problems such as not being able to pay medical bills, being contacted by a collection agency about the bills, or having to change their way of life to pay them.<sup>1</sup> According to another national survey conducted by the Kaiser Family Foundation, in 2005 nearly a quarter (23%) of Americans had problems paying medical bills in the previous year, with one in five (21%) having an overdue bill.<sup>2</sup>

These problems disproportionately affected those with chronic illnesses, who were almost twice as likely as healthier adults to have an overdue medical bill (29% vs. 16%). Those with moderate and lower incomes were also at higher risk of having medical bill problems.

Not surprisingly, the uninsured are at greater risk of having medical bill problems than the insured. The 2003 study found that 59 percent of those who were currently uninsured and 62 percent of those who were insured but had been uninsured at some time in the previous year had medical bill problems or outstanding medical debt, compared to 35 percent of the continuously insured.<sup>3</sup> What is striking in this and other studies, however, is the high percentage of those with insurance who have medical bill problems. The Kaiser Family Foundation found that of the close to a quarter of Americans who had problems paying medical bills in the past year, more than 6 in 10 (61%) were covered by insurance.<sup>4</sup> Another Kaiser study estimated that the number of adults at higher risk of incurring medical bills they might not be able to pay was 58 million; this included 22.9 million adults who were uninsured for the entire preceding year, 17.6 million uninsured for part of the preceding year, and 17.6 million who were continuously insured but with inadequate insurance.<sup>5</sup> The Commonwealth Fund estimated that 12% of insured adults were underinsured—that is, insured all year but without adequate financial protection.<sup>6</sup>

These figures take on particular importance because current trends indicate that the number of underinsured will increase as health premiums, co-payments and deductibles rise. In the Kaiser survey, two-thirds (66%) of insured adults said their health insurance premiums had gone up in the previous five years, with more than a third (38%) saying they had gone up “a lot.” Over half of insured adults (52%) said their co-payments had risen in that time period, and almost half (49%) said their deductibles had risen.<sup>7</sup> In 2005, health insurance premiums increased by 9.2 percent, more than two and half times the overall rate of inflation (3.5%) and almost three and half times the rate of increase in workers’ earnings (2.7%).<sup>8</sup>

### ***Consequences of Medical Debt***

The widespread prevalence of medical debt is of particular concern because the consequences of the debt are so serious. Most directly, medical debt and unaffordable medical bills create a significant barrier to accessing care. According to the Commonwealth Fund, adults with any medical bill or medical debt problem were more than three times as likely as those without these problems to have gone without needed care in the previous year (63% vs. 19%).<sup>9</sup> Moreover, access problems related to debt are not limited to the uninsured. In fact, a Kaiser study found that insured adults with medical debt tend to behave more like the uninsured than like the insured without medical debt in their care seeking behavior.

For example, the study found that 29 percent of the uninsured and 28 percent of the

privately insured with medical debt reported postponing care due to cost, compared to only 6 percent of the privately insured without medical debt. Similarly, 25 percent of the uninsured and 30 percent of the privately insured with medical debt reported skipping a test or treatment due to cost, compared to only 8 percent of the privately insured without debt.<sup>10</sup>

However, the consequences of medical debt are not limited to diminished access to health care. Medical debt can also undermine a family’s financial security through increased expenses, loss of savings, and damaged credit ratings. According to a Commonwealth Fund analysis, among adults with medical bill burdens, over a quarter (27%) were unable to pay for basic necessities, such as food, heat, or rent because of medical bills. In addition, close to half (44%) used all or most of their savings and a fifth (20%) had to take on large credit card debt or a loan against their home to pay off those bills.<sup>11</sup> A recent Access Project survey conducted in eight cities found that a quarter of respondents with medical debt experienced housing problems, such as the inability to qualify for a mortgage, to make mortgage or rent payments, or to secure or maintain a home. This included a fifth of those respondents who were insured when they accrued the debt.<sup>12</sup> Moreover, people who owe medical bills may find themselves in court and subject to legal judgments, including wage garnishment and liens on their homes, which may lead to foreclosure.<sup>13</sup> And medical expenses or lost income due to illness or injury are factors in about half of all personal bankruptcies.<sup>14</sup>

**“ It gives us a lot of worry, because the money we make, we can’t keep up with everything and have to work extra hours. ”**

*-Married woman from Emporia with 3 children  
who owes \$10,000*

## PERSONAL ACCOUNT

### **When hard work and insurance coverage are no protection**

Suzanne and her husband live in Americus, Kansas with five children. Both she and her husband are employed full time and everyone in the household is insured. Two more children live elsewhere: one attending college and the other working a full time job that does not provide health insurance. Suzanne would like to provide more financial support for her child in college—she gives \$27 per paycheck every two weeks—but her precarious economic situation makes it impossible.

The family has accumulated several thousand dollars of medical debt over the past few years because of insurance deductibles and uncovered services. Initially, the couple’s debt resulted from three trips to the emergency room—one when Suzanne’s husband was injured in a farm accident and the other two when their second youngest daughter suffered severe asthma attacks. The debt worsened due to the \$1,500 deductible for care during Suzanne’s pregnancy with her youngest child. The hospital was unwilling to work with Suzanne and her husband to develop a reasonable payment plan, so some of the bills were sent to collection agencies and now appear on their credit report.

The family’s medical debt makes it difficult for Suzanne and her husband to keep up with other bills, including monthly mortgage, car, and student loan payments. In addition, the medical debt contributed to the accumulation of credit card debt used to deal with other unexpected emergencies, such as the replacement of a hot water heater and purchasing safe tires to replace thread-bare ones. With all of these expenses, money is tight for groceries at home and Suzanne often can’t afford to pay for the kids’ school lunches and mandated activity fees. Ongoing health care costs, particularly those related to her daughter’s asthma, further complicate the family’s financial situation—at one point Suzanne had to take out a payday loan with an extremely high interest rate to cover the cost of her daughter’s prescription asthma medication. The family’s slim budget forces Suzanne to make hard choices about when to seek care and what procedures, tests, and prescriptions are really necessary. Although Suzanne has health problems of her own, she often delays treatment so she can pay for her children’s care.

# Methodology

The findings in this report are based on a survey that was conducted at four community health centers in Kansas: GraceMed Health Clinic, Inc. and Hunter Health Clinic in Wichita, United Methodist Mexican-American Ministries in Garden City, and Flint Hills Community Health Center/Lyon County Health Department in Emporia.

The survey was conducted between May and August of 2005, using a written questionnaire developed jointly by The Access Project, Brandeis University, and representatives from the four community health centers participating in the study. It was first pilot tested in Garden City in April. To minimize selection bias, every patient who registered at the health center during the period in which the survey was being conducted was asked to participate. Patients were assured both that their answers would be confidential and that declining to participate would not affect their receipt of services. The questionnaire was administered either by a surveyor who had participated in a four-hour training session on the survey instrument, or was self-administered by the respondent, with trained surveyors nearby to supply needed clarifications. Information supplied for the survey was self-reported and not verified by other sources. The questionnaires were available in English and Spanish .

A total of 1,058 surveys were completed.

# Findings

## RESPONDENT CHARACTERISTICS

Of the 1,058 adults who completed the surveys, 72 percent were female and 28 percent male. Almost half (45%) were married, 31 percent were single, 12 percent divorced, 6 percent separated, and 4 percent widowed.

A third of the respondents (32%) were white and almost half (47%) were Hispanic. Blacks constituted 8 percent of the sample, Asian/Pacific Islanders 11 percent, and American Indians 5 percent. The majority of survey respondents (53%) was born in the United States, with those born outside of the country constituting a large minority (47%). Twenty nine percent chose to take the survey in Spanish.

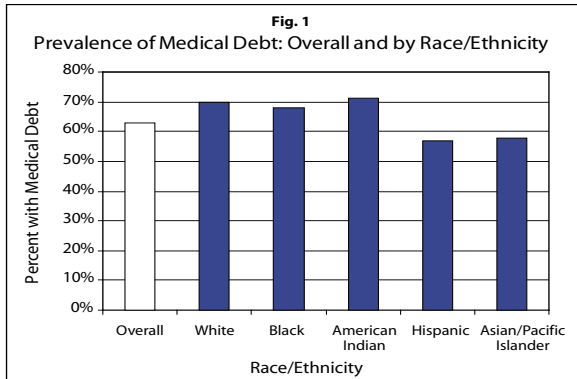
Respondents were generally from low-income families—the average household income was \$20,216 and the median income was \$17,000. Three-quarters of the respondents (75%) had incomes below \$25,000, and 90 percent below \$40,000. While respondents' incomes were lower than in the state as whole, where the average median income for the combined years 2002-2004 was \$43,725,<sup>15</sup> they still reflected the situation of a significant portion of the Kansas population. In 2002, 20 percent of all Kansas families, or over 138,000 households, had incomes below \$25,000.<sup>16</sup>

Forty three percent of the respondents were unemployed, 17 percent were employed part-time, and 41 percent were employed full-

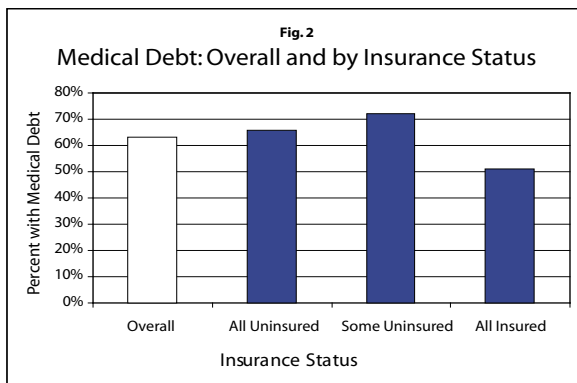
time at the time of the survey.<sup>17</sup> Almost 3 in 10 respondents (29%) said everyone in their household had health insurance continuously over the last year. Almost 4 in 10 (39%) said at least some household members had not been insured during the year. A quarter of the respondents said everyone in their family had been uninsured for all of the preceding year. There were no major differences in employment status and insurance coverage between those born in and outside of the United States.

## PREVALENCE AND SOURCES OF DEBT

The survey indicated a high prevalence of medical debt among respondents, nearly two-thirds of whom (63%) reported currently owing money for medical bills. Over half of respondents in each of the racial and ethnic groups had medical debt. Whites (70%), blacks (68%), and American Indians (71%) had the highest rates, while rates among Hispanics (57%) and Asian/Pacific Islanders (58%) were somewhat lower. Rates of medical debt for immigrants were actually lower than for the native born: 43 percent of those born outside of the country had medical debt compared to 57 percent of those born in the United States. Within this low-income sample, the prevalence of medical debt did not vary greatly by income group.



The prevalence of medical debt was higher for those in families where everyone was uninsured (66%) and in households where some people were uninsured during the previous year (72%). However, even among people in households where everyone was continuously insured over the previous year, over half (51%) reported having medical debt.<sup>18</sup>



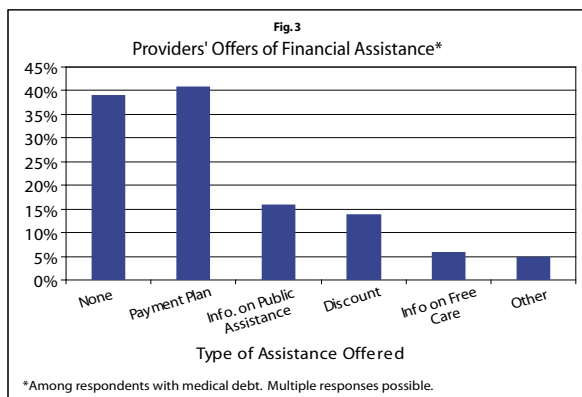
The most commonly cited sources of debt among those with debt were hospitals (mentioned by 71% of respondents) and doctors (62%). Other significant sources of debt included dentists (29%), prescription medications (14%), and ambulance services (11%). Among those with health insurance, the most commonly cited reasons for the debt were deductibles and co-payments (68% each). Twenty percent of the insured with debt reported that it stemmed from both deductibles and co-pays.

“ I had to decide what’s more important, a place to live or dental or vision care, a child’s health issues or groceries. ”

-Woman from Wichita who owes \$775

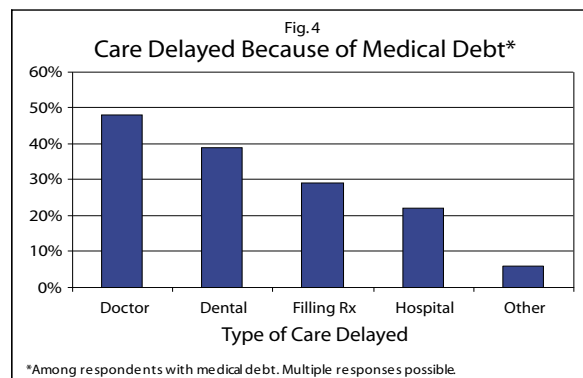
## OFFERS OF FINANCIAL ASSISTANCE

Among respondents with medical debt, almost 4 in 10 (39%) reported receiving no offers of financial assistance from their medical providers. A similar percentage (41%) said their providers offered them a payment plan. Sixteen percent said they were informed about the availability of public coverage programs, and only 14 percent said they had received a discount on their bill. It is possible, however, that some patients were unaware that they were being billed at reduced rates. At one of the health centers participating in this study, for example, patients with incomes below 200 percent of the federal poverty level automatically receive significant discounts, but they may not realize that their fees do not reflect full charges.



## EFFECTS OF MEDICAL DEBT ON ACCESS TO CARE

Having medical debt significantly affected people's ability to access care. Nearly half of those with debt said they delayed a doctor's visit because of the debt (48%), while nearly 4 in 10 (39%) delayed a dental visit. Almost 3 in 10 (29%) delayed filling a prescription, and more than 2 in 10 (22%) delayed a hospital visit.

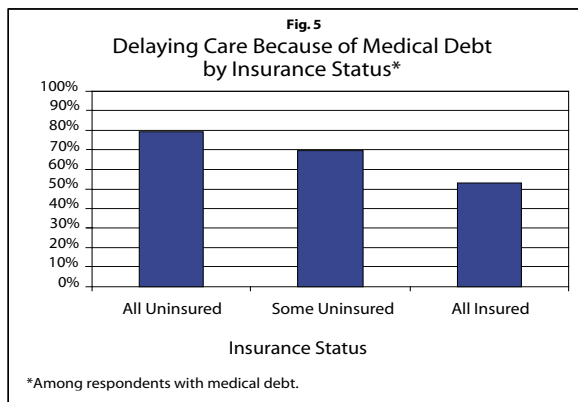


Many of those who delayed care said they did so because of embarrassment (59%) or because they did not want to increase their debt (63%). One out of 6 respondents (17%) who delayed care said they were refused an appointment because of the debt, an occurrence reported most frequently by respondents in Wichita.

“ Some people told me there is an account where the hospital can write the bill off, but the hospital did not tell me about it... ”

-Divorced working mother of 4 from Wichita who owes \$13,000

Delaying care because of medical debt affected large portions of both the uninsured and the insured. It was reported by the vast majority of respondents who lived in households where everyone was uninsured (79%), as well as by those in households where some members had a time without insurance (70%). Even among those who lived in households where everyone was insured, over half (53%) reported delaying care because of their debt.



**“ I haven’t seen a doctor for a year, because I can’t pay the deductible—it is so high. ”**

*-Married woman with 4 children from Garden City who owes \$3,645*

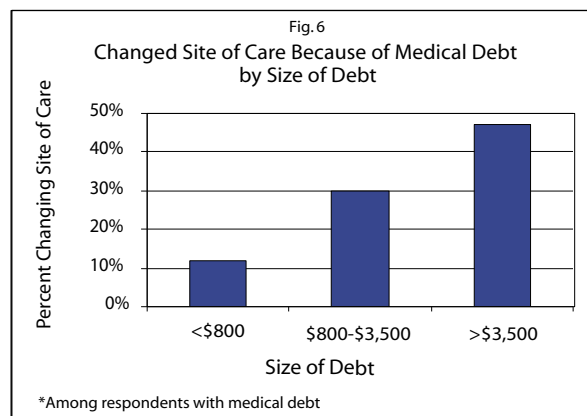
Just over 1 in 4 of those with debt (26%) changed doctors or the site at which they received primary care because of the money they owed, indicating that medical debt had a

significant impact on continuity of care. With respect to insurance status, the uninsured for the entire year were most likely to have changed their site of care (35%).

**“ I really need new teeth, but I cannot get them, so I just live with the pain. ”**

*-Woman from Wichita who owes \$7,000*

Even among those with relatively small amounts of medical debt (under \$800), a portion said they had changed sites of care because of the debt (12%). However, the likelihood of changing sites of care increased dramatically with even small increments in the debt. Those with debts between \$800 and \$3,500 were two and a half times as likely to change sites of care because of their debt (30% of respondents with debt) as those with debts under \$800, while those with debts over \$3,500 were almost four times as likely (47%).



**“ My husband has no insurance. He has medical problems, back problems, but he will not go because it costs so much. ”**

*-Married woman from Emporia  
who owes \$500*

## PERSONAL ACCOUNT

### The price of living with disability

Don lives in a rural area in central Kansas. In the mid 1990s, he was diagnosed with an unknown neuromuscular disease that left him with weakness and pain in his legs and eventually necessitated hip replacement surgery. In 2002, he was injured on the job while working for a Farmer’s co-op, which exacerbated his condition. He has not been able to work since due to debilitating pain and difficulty walking. Although he applied for Social Security Disability Insurance soon after leaving the co-op, he only began receiving benefits in November of 2004.

Don was uninsured for over a year after his injury. During this time, he avoided getting care because he did not want to rack up unaffordable medical bills. Pain sometimes forced him to seek treatment, however, which resulted in almost \$2,000 in medical debt. His unpaid medical bills were turned over to a collections agency, which placed a lien on his property. Barely able to walk and fearful of accruing new debt, Don attempted self-treatment, relying on over-the-counter medications and purchasing a pair of crutches that he still uses. At one point, Don had to choose between paying down his medical debt and paying his utility bills. He chose the former and went without electricity for a week. He received Medicaid coverage in 2003 but, because of his economic circumstances, was still required to pay \$2,600 annually, which led to additional debt. Don finally refinanced his home to pay off the majority of his medical bills—a step he took reluctantly because he had owned the property free and clear for years.

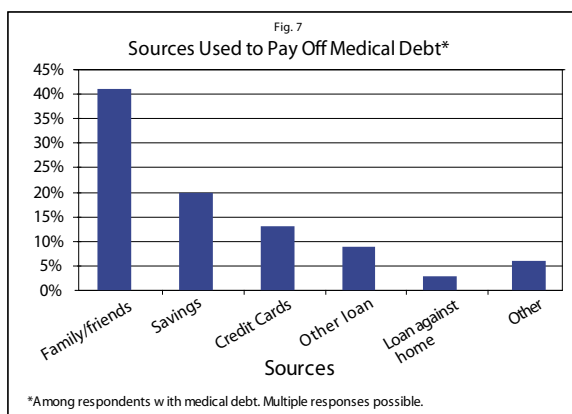
Don had avoided seeing a dentist for many years due to lack of dental coverage. Because of lack of preventative care, his dental health deteriorated. At the same time, Don’s hip problems worsened and a surgeon recommended that he get both hips replaced, including the artificial one. The surgeon could not perform the operation until Don’s dental problems were cleared up, however. Although Don is now covered by Medicaid, it only pays for extraction of teeth and not preventative care or dentures. Thus, Don had six teeth removed and was unable to have them replaced. Don hopes to be healthy enough to go back to work after he recovers from the double hip replacement surgery. He worries, however, that his lack of teeth will discourage potential employers from hiring him despite his skills and experience.

## FINANCIAL EFFECTS OF MEDICAL DEBT

Along with diminishing access to care, medical debt had significant and wide-ranging economic consequences for people, for example by depleting their savings and creating long-term credit, housing, and employment problems.

### Sources Used to Pay Off Medical Debt

Most respondents with debt struggled to pay it off. More than 4 in 10 (41%) borrowed money from friends or family to pay their bills, while 2 in 10 (20%) used a large part of their savings to pay for care. Thirteen percent increased their credit card debt to pay medical bills, 9 percent took out a loan, and 3 percent borrowed money against their homes. Multiple responses were possible for this question, so respondents may have used more than one of these methods to try to pay their bills.



### Collections and Credit Problems

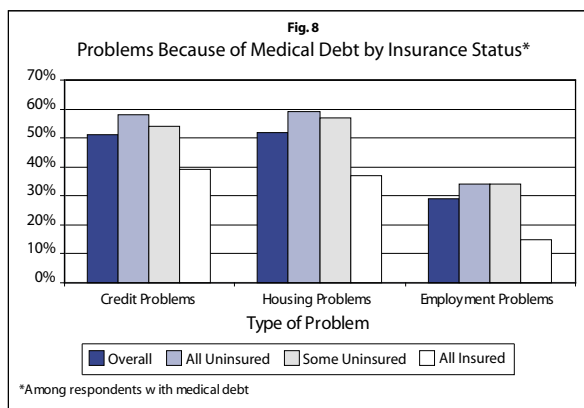
Almost two thirds (65%) of those with medical debt said they were contacted by a collection agency, and 13 percent were sued in small claims court. It is interesting to note that 7 percent of respondents with debt said providers suggested they use a credit card to pay their bills, and 5 percent said providers suggested they take out a loan, both of which are expensive options, particularly for low-income people.

“It will take a long time to pay off the debt since, even after taking me to court, the payments I make only go towards the interest, which is still accumulating.”

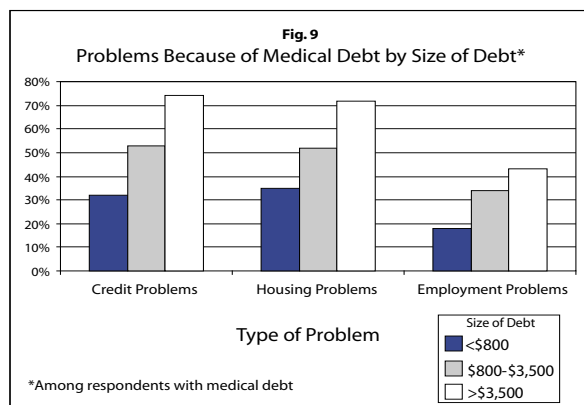
-Married woman from Emporia who owes \$7,000

Among those with medical debt, half (51%) said the debt made it harder for them to get loans and credit, and 11 percent had filed for bankruptcy. Those who lived in households where everyone was uninsured for the entire year or where some members had a time without insurance were more

likely to experience this problem (58% and 54% respectively). Even in households where everyone was continuously insured, nearly 4 in 10 of those with medical debt (39%) experienced credit problems as well.



While the likelihood of having problems getting loans or credit affected almost a third of those with relatively small debts (32% of those with debts less than \$800), it increased dramatically with even small increases in the size of the debt; these problems were experienced by over half (53%) of those with debts between \$800 and \$3,500, and almost three quarters (74%) of those with debts over \$3,500.



“ Sometimes it’s hard for me to get a loan because of my hospital bills. It shows on my [credit] record. ”

-Married man from Wichita with 4 children who owes \$2,500

“ We have been denied a line of credit several times. ”

-Young married couple from Wichita who owe \$10,000

### Housing Problems

More than half (52%) of those with medical debt reported the debt contributed to housing problems. Of those with housing problems, 6 in 10 (60%) said it made it harder to pay rent or a mortgage, a quarter (25%) had been turned down from renting a house or apartment, 17 percent had been unable to get a mortgage, and 12 percent were forced to move.

While housing problems were most severe among those in households where people were uninsured for all or part of the year (approximately 57% of each group), housing problems also affected more than a third (37%) of those in households where everyone was continuously insured (Fig. 8).

**“ I had to move in with a friend because I couldn’t pay the rent and utilities all by myself. ”**

*-Young woman from Wichita who owes \$76,00*

Even small amounts of debt created housing problems, which affected over a third (35%) of those with debts less than \$800. However, small increases in the amount of debt greatly increased the likelihood of housing problems, which were experienced by over half (52%) of those with debts between \$800 and \$3,500 and almost three-quarters (72%) of those whose debts exceeded \$3,500 (Fig. 9).

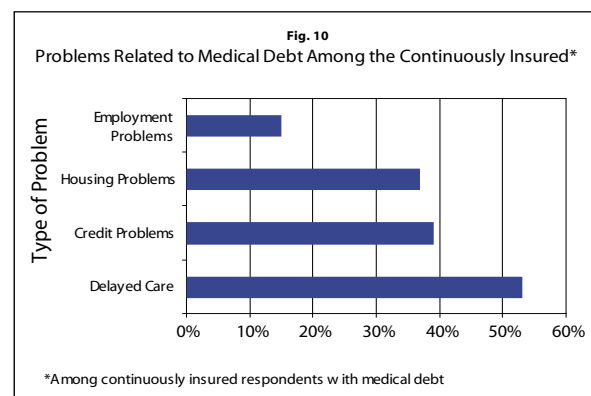
**“ We have had to move three times in a four year period. We lost one home due to foreclosure... ”**

*-Young married couple from Wichita who owe \$10,000*

## Employment Problems

Among those with medical debt, almost 3 in 10 (29%) said the debt contributed to employment problems for them or a family member. Of those with employment problems, almost 6 in 10 (58%) said they increased their work hours or took an additional job, 3 in 10 (30%) saw their wages withheld, and almost a quarter (23%) had been denied a job because of poor credit.

About a third of those in households where everyone was uninsured for the entire year or where at least some members were uninsured for part of the year experienced employment problems. Even among the continuously insured, 15 percent experienced employment problems (Fig. 10, see also Fig. 8).



Employment problems followed the same pattern as credit and housing problems—they occurred among those with relatively small amounts of debt, but were more likely to occur as the size of the debt increased. Almost 2 in 10 respondents (18%) with debts less than \$800 said they experienced employment problems, but the percentage more than doubled (43%) for those with debts greater than \$3,500 (Fig. 9).

“ **Applying for jobs is difficult because employers check everyone’s credit.** ”

*-Single woman from Wichita who owes \$20,000*

## PERSONAL ACCOUNT

### The financial and human costs of “accidental” debt

Malcolm was seventeen years old in 2000, when he was a passenger in a terrible car accident. The accident took place in Colorado, five and a half hours from his home in Garden City, Kansas. Malcolm was admitted to the trauma unit of a hospital in Colorado Springs, where he remained for ninety days. The accident not only seriously threatened Malcolm’s health; it also imperiled his family’s financial stability. The cost of his care totaled more than one million dollars. Although Malcolm was covered by both of his parents’ health insurance policies—a result of their divorce settlement—the enormous costs of treatment, multiple surgeries, and hospitalization quickly exceeded the payment caps of both insurance plans. Malcolm’s family was left with over \$200,000 of debt. To pay off the bills, Malcolm’s mother, Dorothy, has been forced to work two or three jobs at once, which she finds especially difficult with a ten year old son at home.

Malcolm made a remarkable recovery from the accident, although his injuries forced him to live with a colostomy. Further surgery could repair his intestines, but the cost is prohibitive, and Malcolm and Dorothy decided it would be better to pay off the existing debt before racking up more medical bills. Since the accident Malcolm attended college, graduating in May of 2005, and found work as an auto body technician. The job does not provide health insurance, however, so the gastrointestinal surgery must be postponed until Malcolm can find employment that offers coverage. Even then, he may not be able to get the needed procedure because he will be unable to work during the six to eight months required for recovery.

# Discussion

The findings of this survey contradict some commonly held notions: that people can always get health care if they need it, even if they can't pay for it; that many patients have the resources but simply refuse to pay for their care; and that insurance protects people from financial jeopardy resulting from illness.

**“ I will probably be paying off my debt for the rest of my life. ”**

*-Young woman from Wichita who owes \$200,000*

In this survey of over 1,000 Kansans in three communities, nearly two-thirds had unpaid medical bills. All racial and ethnic groups were affected—more than half of each surveyed group owed money for health care—with the native born having even higher rates of medical debt than immigrants. Those with debt struggled to pay for this care, for example by taking on additional jobs, using a large part of their savings to cover the costs, or borrowing money from family and friends. Moreover, while respondents in households where everyone was uninsured or where some members were uninsured for

at least part of the time were at greatest risk for medical debt, this problem also afflicted significant portions of the insured—over half of respondents in households where everyone was continuously insured in the previous year reported having medical debt.

The consequences of medical debt were also felt across racial and ethnic groups, and among both the uninsured and the insured. Unpaid medical bills caused high percentages of respondents with medical debt to delay needed care—including over 60 percent of respondents in each racial or ethnic group, as well as over half of those in households where everyone was insured. Most said they did so because of embarrassment over their debt or an unwillingness to add to it, a finding that undermines the notion that people simply don't want to pay their bills. Medical debt also led over a quarter of the respondents with such debt to change the sites at which they received primary care, thus disrupting continuity of care and potentially creating unnecessary costs through duplication of procedures.

**“ I just quit going to the doctor. ”**

*-Man from Emporia who owes \$3,000*

Along with access problems, medical debt resulted in an array of financial problems, which frequently interacted in ways that added to people's financial burden and increased the difficulty of paying off their medical bills. Some respondents paid their medical bills by putting them on credit cards or by taking out loans, both options that subject low-income people to significant additional expenses resulting from interest charges. Some people even borrowed against their homes to pay their bills, potentially putting their residences at risk if they are later unable to repay the loan.

**“ I will never own a home or receive credit because of so many years of ongoing [medical] debt. ”**

*-Woman from Wichita who owes \$12,600*

For over half of the respondents with medical debt, the difficulties were compounded by the fact that having unpaid medical bills made it harder for them to get loans or credit, which may in turn have forced them to take out even higher interest loans and thus incur additional financial burden. More than 1 in 10 respondents with medical debt were even forced into the extreme measure of declaring bankruptcy because of their medical debt.

**“ I lost my job. I had to file for bankruptcy. I had \$42,000 in debt. ”**

*-Man from Wichita*

Medical debt also resulted in serious housing and employment problems. More than half of the respondents with medical debt experienced housing problems. Some found it harder to pay their rent or mortgage. Others were turned down from renting a house or apartment or were unable to get a mortgage, both likely effects of damaged credit. In addition, close to a third experienced employment problems, including having to increase their work hours or having wages withheld. Almost a quarter were denied a job because of poor credit resulting from unpaid medical bills, which may have made it harder for individuals to earn sufficient income to pay off their bills. As with access problems, housing, employment, and credit problems significantly affected the insured as well as the uninsured—more than a third of the continuously insured with medical debt experienced housing problems, 15 percent experienced employment problems, and nearly 4 in 10 experienced problems relating to getting credit.

It might be noted that the comments of many respondents also suggest an additional consequence of medical debt—enormous

stress and anxiety, which in some cases negatively affected people's health. This comment from one respondent was typical: "It has put a strain on me because I worry about the bills. It stresses me out and then I get sick." Another said, "We are now very stressed out all the time [because of the debt]. My home life is on eggshells." Although this study does not allow us to quantify the percentages of patients reporting enhanced stress resulting from medical debt, other studies have documented the damaging impact that medical debt can have on people's emotional well-being.<sup>19</sup>

**“ We have hospital bills, which stress me.... Worrying affects my illness. ”**

*-Man from Garden City*

The findings on the high rates of medical debt among the insured call into question current policy approaches that advocate increased cost-sharing by consumers to restrain health care costs, and the provision of less expensive "bare bones" insurance policies to make insurance more affordable. Those who support increased cost-sharing by consumers, usually in the form of higher deductibles and co-payments, identify inappropriate utilization of services as the major cause of spiraling health care costs in this country. These advocates believe that, because some health care costs are covered by insurance, policy holders do not have enough of a financial stake in

choosing appropriate over inappropriate care, and that increased consumer cost-sharing would encourage them to make wiser choices when seeking care. In Missouri, for example, the head of the Washington-based Center for Health Transformation testified before a state commission studying health care reform that "People would behave differently in the health care marketplace if it were their dollars at stake."<sup>20</sup> Those who propose allowing insurers to market less expensive "bare bones" health insurance policies see such coverage as "better than nothing," and believe it will help reduce the large percentage of Americans who are uninsured.

**“ Two years ago I needed occupational therapy for my arm.... All of my therapy was approved [by the insurance company], yet when I finished... I got a bill totalling over \$1,300. I can't now and couldn't pay it then. ”**

*-Woman from Wichita who owes \$2,500*

The results of this study contradict many of the assumptions underlying these proposals. The survey findings indicate that many low-income people, including the insured, already face health care costs that they simply do not have the resources to pay. Rather

than “frivolously” seeking inappropriate services, many have exhausted their savings and others are already forgoing care out of embarrassment or an unwillingness to add to their debt. Since other research has shown that consumers, faced with increased costs, tend to equally reduce appropriate and inappropriate care, it is likely that much of the foregone care is appropriate and needed.<sup>21</sup> In addition, the findings suggest that even relatively small amounts of debt can both diminish access to care and create serious financial hardships. Survey respondents with debts under \$800—well below the deductibles proposed for many high deductible and “bare bones” health insurance plans—suffered high levels of housing, employment, and credit problems, while even relatively small increments to this amount vastly increased the likelihood of these consequences. Rather than alleviating

problems, increased consumer cost-sharing and “bare bones” health insurance plans may undermine the very purpose of health insurance, which is to protect people against financial catastrophe if they are unlucky enough to become ill.

Finally, data from the survey suggest that health care providers could do a better job of assisting low-income people to identify sources of financial assistance to help pay their bills, including public coverage programs, such as Medicaid and HealthWave, and private programs, such as hospital discounts and charity care. In the survey, nearly 4 in 10 respondents with medical debt said they were never offered financial assistance by providers, and only 16 percent said they were told about available public programs.

## PERSONAL ACCOUNT

### The cost of not having insurance: working hard and barely getting by

Dena\* is a middle-aged American Indian woman who receives care at a Community Health Center in Wichita. She works full-time, earning \$23,000 a year. Her employer does not offer health benefits, however, so she is uninsured. Dena has a chronic illness and needs regular treatment, but without insurance to help pay her health care expenses, she has accumulated \$13,000 in unpaid medical bills. Because of the debt, she has been contacted by a collection agency and also had to change her primary care provider. She now often delays seeking health care because she feels uncomfortable about owing money and does not want to increase her debt.

Dena writes:

*“A lady from [the hospital] had me apply for help from SRS [Kansas Department of Social and Rehabilitation Services] but I made too much money. Now I can’t qualify for loans, because my credit is bad. I have stopped cable, internet, and try not to use gas for the car, or electricity and water to keep the cost of living down. But I can’t seem to catch up. I don’t spend money on alcohol or nice clothes or anything but it just seems like I barely get the monthly bills paid. I wish we had an IHS (Indian Health Service) hospital nearby to help those of us who make too much for SRS but can’t afford health insurance.”*

\*The name and some minor details were altered to protect confidentiality.

# Recommendations

**M**edical debt is a problem that is likely to worsen as health care costs rise at rates far exceeding increases in wages or general inflation, as the numbers of uninsured rise, and as consumers are increasingly expected to bear more of the costs of care. It is also a complex problem with multiple causes that does not lend itself to quick fixes or easy remedies. However, actions by the range of players that influence health care costs and coverage—providers, insurers, and the government—could help reduce the prevalence of medical debt and alleviate some of its consequences.

## **Maintain and expand public insurance programs such as Medicaid and HealthWave.**

Providing access to affordable primary and preventative care has the potential to reduce medical debt, as well as to create overall savings by giving people access to treatment before their conditions become more difficult and expensive to treat. One way to provide such access is by enrolling low-income people in public insurance programs such as Medicaid and HealthWave. Any measures that maintain or expand eligibility for and enrollment in public insurance programs have the potential to alleviate the problem of medical debt. At the same time, measures that shift more costs on to Medicaid or other public insurance enrollees are likely to increase the problem of medical debt. Medicaid beneficiaries already pay a significant share of their health care costs out-of-pocket—12 percent of their health care expenses according to one study. In addition,

increasing premiums and cost-sharing, even when the amounts are modest, has resulted in decreased enrollment in the program, increased levels of unmet medical need, and increased financial stress among these most vulnerable families.<sup>22</sup>

**Maintain and expand the capacity of safety-net facilities.** Another way to reduce medical debt is to increase the capacity of safety net facilities, which provide affordable care for people of limited means. The 35 safety net clinics in Kansas, which provide comprehensive primary health care, currently serve many low income patients (86 percent of their patients have incomes below 150 percent of the Federal Poverty Level) and many patients who lack insurance (67 percent of their patients).<sup>23</sup> Funding these facilities may also be cost-effective. Research in Kansas found that the availability of safety-net clinics reduces the number of hospital emergency room visits by uninsured patients, potentially saving hospitals significant outlays for uncompensated care. Patients at safety-net clinics also used preventative health services at higher rates than the general population, which may reduce expenditures for more intensive treatment that can be required when health problems are not addressed in a timely way.<sup>24</sup>

Legislation passed in Kansas in the last two years to provide these clinics with operational funds and funds for affordable medications are steps in the right direction and should be maintained. Increasing the capacity of the

safety net to offer other types of services, such as dental care, could also be useful, especially as almost 3 in 10 (29%) survey respondents mentioned dentists as the source of their medical debt.

**Improve health care providers' policies related to billing, collection, and screening for eligibility in public or private financial assistance programs.** In the last few years, there has been a great deal of attention directed towards health care providers' billing and collections practices towards the uninsured. In particular, the public has become aware that hospitals and other providers often expect the uninsured to pay far more for the same services than the insured, who have access to negotiated discounts, and that providers then often use overly aggressive collection methods, such as wage garnishments and property liens, to try to extract payment. As a result of this attention, some hospitals have revamped their practices by offering greater discounts or free care to low-income uninsured patients, and by restricting some of the more egregious collection methods. However, many hospitals have not addressed their policies at all, and some that have revised their policies have not made them well known to the public.<sup>25</sup>

In this survey, hospitals were the most frequently cited source of debt, mentioned by more than 7 in 10 respondents. At the same time, almost 4 in 10 respondents with medical debt reported receiving no offers of financial assistance from their health care providers,

including hospitals, while only 14 percent said they had received a discount on their bills and only 16 percent were informed about the availability of public coverage programs.

These findings suggest that hospitals and other health care providers could help reduce medical debt and potentially enhance their revenues by doing better screening of patients for eligibility for public programs, such as Medicaid and HealthWave. In addition, they could implement and publicize charity care programs that provide access to care for those without resources to pay.

For those patients in need who do not qualify for full free care, providers should offer significant discounts and reasonable payment plans that are tailored to people's available resources and actual ability to pay. Providers should avoid suggesting methods of payment, such as credit cards or loans, that can increase patients' overall financial burden through high interest charges. These methods of payment can also potentially cause long term damage to patients' credit if they become unable to keep up with their payments in the future.

**Consider restricting the reporting of medical debt to credit agencies.** Some lenders and credit-scoring organizations have come to consider medical debt as "atypical and non-predictive" of overall credit worthiness because of its involuntary nature, and have said they segregate medical debt when considering applicants' eligibility for

credit.<sup>26</sup> However, medical debt can be hard for potential lenders to identify on credit reports, especially if consumers transform their medical debt into other forms, such as credit card debt or home equity loans, or if the collection agency rather than the health care provider appears as the creditor.

This study indicates that many consumers are still experiencing major barriers to obtaining credit because of their unpaid medical bills—reported by half of the respondents in this survey with medical debt. While the study did not track whether medical debt appeared on respondents' credit reports, other research has shown an association between having medical debt on credit reports and an increased likelihood of experiencing housing problems.<sup>27</sup>

Given this research, policy makers might want to further investigate how medical debt on credit reports affects consumers and consider whether health care providers should be allowed to report medical debts to credit-reporting agencies.

**Provide financial counseling to patients facing unaffordable medical expenses to help them resolve bills and avoid assuming unmanageable debt.** Patients faced with unaffordable medical bills may be unaware of financial assistance programs that are available to them and unable or too intimidated to negotiate discounts with providers. In these situations, they sometimes make use of expensive and risky strategies

to pay their bills, such as putting them on credit cards, taking out expensive predatory loans, or converting unsecured medical debt into secured debt by borrowing against their homes. Organizations that provide financial counseling to lower-income people could work with their clients with medical debt to help them investigate the availability of financial assistance options and/or negotiate discounts and manageable payment plans with providers. At the same time, these organizations could discourage their clients from taking on expensive and unaffordable debt that in the long run could undermine their financial stability.

**Ensure that health insurance coverage provides policy holders with both access to care and protection from financial ruin.**

The fundamental purpose of health insurance is to protect policy holders from damaging financial consequences if they become ill. Yet national studies have documented high rates of medical debt among the insured as well as the uninsured. They have also found that the care seeking behavior of the privately insured with debt is more like that of the uninsured than like the privately insured without debt—that is, privately insured patients with medical debt are as likely as the uninsured to delay or forgo needed care.

This study reinforces these findings. It found high rates of medical debt among the insured, with significant effects on their access to care and financial stability. These findings call into question the adequacy of many insurance

products in guaranteeing their policy holders access to care and financial protection, just at the time that insurers are increasingly marketing insurance products with increased consumer cost-sharing that provide less rather than more protection.

In the face of these trends, more attention needs to be paid to the design of health insurance policies. Kansas is currently exploring initiatives to offer more affordable health insurance policies to small business owners. In doing so, it needs to ensure that policy holders are not exposed to potentially ruinous levels of financial risk. For example, policies could limit cost-sharing obligations to reasonable percentages of policy holders' incomes. In this regard, it should be noted that even those respondents in this survey who had debts under \$800 faced significantly reduced access to care and negative financial consequences.

# Conclusion

**R**esearch has consistently documented that medical debt is widespread, with the poor and chronically ill most at risk, and that its consequences are long lasting and damaging. This study demonstrates that low-income Kansans are in no way immune from the problem of medical debt, and from the diminished access to care and the financial insecurity that follow in its wake.

Because this is a complex and multifaceted problem, remedying it will require action at all levels, from national and state governments and local communities to private participants in the health care sector, such as providers and insurers. While an overall solution to the problem of medical debt may require major structural changes in the way this country finances and delivers health care, many steps can be taken at state and local levels to reduce its prevalence, mitigate its consequences, and help those vulnerable people in our society with limited resources who are unlucky enough to become ill.

# Endnotes

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- <sup>15</sup> U.S. Census Bureau, *Three-Year-Average Median Household Income by State: 2002-2004*, <http://www.census.gov/hhes/www/income/income04/statemhi.html>.
- <sup>16</sup> U.S. Census Bureau, *American Community Survey Profile 2002 Kansas: Table 3 Selected Economic Characteristics*, <http://www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/Tabular/040/04000US203.htm>.
- <sup>17</sup> The survey asked respondents about *their* employment status only. It is possible that some respondents who were unemployed had working spouses. This is especially likely as almost three-quarters of the respondents in the survey were female. Thus, the percentage of respondents in

families with an employed adult is probably higher than the reported percentage of employed respondents.

<sup>18</sup> In the survey, people indicated whether every member of their household had health insurance during the previous 12 months, whether some household members had a time without health insurance, or whether all household members were uninsured for all of the last 12 months or were never covered. These are the categories used in this report to identify people as all insured, some uninsured, or all uninsured. Because people may have incurred medical debt more than a year before they took the survey, it is possible that the reasons for their debt do not reflect their current insurance status. However, comparison of respondents' answers about their insurance status with their answers about the reasons for the debt (e.g. no insurance, insurance deductibles, insurance co-payments, and so on) indicate that the vast majority (87%) of those who were identified as all insured incurred their debt while insured, and the vast majority (88%) of those who were identified as all uninsured incurred their debt while uninsured. Among those identified as some uninsured, 55 percent had medical debts resulting from lack of insurance, 35 percent had debts resulting from gaps in insurance coverage, and 10 percent had both types of debt.

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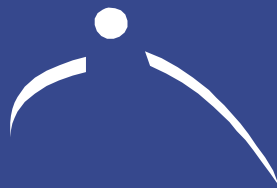
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The Access Project

89 South Street, Suite 404

Boston, MA 02111

(617) 654-9911

(617) 654-9922 fax

[www.accessproject.org](http://www.accessproject.org)