Getting Care But Paying the Price:

How Medical Debt Leaves Many in Massachusetts Facing Tough Choices

February 2004

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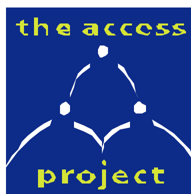

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THE ACCESS PROJECT

The Access Project is affiliated with the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources.

The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. The Access Project conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

If you have any questions or would like to learn more about our work, please contact us.

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EXECUTIVE SUMMARY

The last few years have seen a significant increase in the numbers of both people without health insurance and those with inadequate insurance. Rising health care costs have led employers to shift more of the costs on to employees through higher premiums and co-payments, while state revenue shortfalls have led to major cuts in public coverage programs. Both national and state data show that the uninsured and, increasingly, the underinsured face major difficulties in trying to pay for health care. In 2003, 28 percent of uninsured Massachusetts residents, and seven percent of insured residents, reported delaying or forgoing care due to cost.

Along with reducing access to care, medical expenses often drive families into debt, which can jeopardize their financial security as well as their health. A national study reported that more than one-quarter of families in which one or more members were uninsured said they had to "change their way of life significantly" to pay medical bills. Interviews with low-income people with medical debt found that the debt seriously affected their ability to access credit, save money, and pay for daily necessities.

Massachusetts has historically had a relatively strong safety net. Recent expansions in eligibility for public health coverage programs such as MassHealth (Medicaid) have provided coverage to many. In addition, the state's Uncompensated Care Pool provides partial reimbursement to hospitals to help cover the costs of charity care for patients who are eligible. However, like other states facing rising health care costs and state revenue shortfalls, Massachusetts has implemented cuts in public programs that will remove coverage or reduce access for thousands of state residents. As a result, problems related to medical debt among Massachusetts residents are likely to worsen.

Perhaps because of the existence of the Uncompensated Care Pool in Massachusetts, discussions about rising health care costs and the costs of uncompensated care tend to focus on their impact on institutions that serve the uninsured, such as hospitals and health centers, or on taxpayers generally, rather than on the uninsured and underinsured themselves. This report presents the findings of a survey of clients at two safety net facilities that looked at the impact of the cost of health care and resulting medical debt on individuals and their families. Clients at the Codman Square Health Center in Boston and the Lynn Community Health Center in Lynn were asked about whether they had medical debt from any sources, and about its health access and economic consequences.

Key Findings

Prevalence

- Medical debt is a serious problem for many people. Of the 342 people surveyed, more than 4 in 10 (41%) reported having medical debt.

- The problem of medical debt is widespread. While respondents with medical debt were more likely than those without debt to be unemployed, uninsured, and have lower incomes, almost three of ten (29%) respondents who were continually insured over the past year had medical debt, as did a third (33%) of respondents with incomes above $25,000.

Sources

- The most common source of medical debt was hospitals, reported by 79% of respondents with debt. Further research is needed to determine the extent to which this debt is for services covered by the Uncompensated Care Pool, or for costs related to a hospital stay that are not covered by the Pool.

- Doctors, ambulance services, dentists, and pharmacies were also significant sources of debt.

- The uninsured were more likely than the insured to report that their debt was the result of getting routine care.

Consequences

- Almost six in ten respondents (59%) said their medical debt caused them to delay getting needed health care. Most of these respondents said they delayed care because they were uncomfortable about their bills (73%), but 30 percent said they were asked to pay cash upfront, and 14 percent said they were denied care altogether.

- Medical debt undermines people's ability to achieve economic self-sufficiency. Over half of the respondents with medical debt (53%) said it caused them housing problems, such as being turned down from renting a house or apartment or having difficulty paying the rent or mortgage. Over a third (39%) said it caused employment problems, such as having to increase work hours or being denied a job because of bad credit.

Provider Behavior

- Many people ended up with medical debt despite the fact that providers did a relatively good job of informing them about the availability of free care and public assistance. Over two-thirds of respondents with debt (67%) said they had received such information.

- Almost two-thirds of respondents with debt said they had been contacted by a collection agency, while 16 percent were sued in small claims court because of the debt.

RECOMMENDATIONS

- Policy makers need to consider both the health-related and economic effects of rising health care costs and the lack of adequate health insurance on individuals and their families when trying to craft solutions to these growing problems.

  The survey results undermine the common perception that it is primarily provider institutions and tax payers who bear the costs of care for uninsured and underinsured people. In particular, the high rate of hospital debt among survey respondents suggests that despite the existence of the state's Uncompensated Care Pool, people who need hospital care can still face serious financial burdens.

- Policy makers must ensure that current Uncompensated Care Pool regulations are consistently implemented, and that changes to the Pool do not lead to increased medical debt.

  Massachusetts must ensure that all patients who qualify for assistance from the Pool know about the program and receive help in applying for it. In addition, policy makers are now considering replacing the Pool with a new mechanism for financing care for low-income uninsured people. Any new system must retain and even strengthen the consumer protections now included in the Pool's regulations that help prevent medical debt.

- Further research is needed to learn more about the causes of the high incidence of medical debt from hospitals, the reasons for medical debt among insured people, and the nature of medical debt from non-hospital sources.

I. INTRODUCTION

In 2000 The Access Project, in collaboration with 24 community organizations in 18 states, conducted a survey of uninsured patients who received care in local safety-net facilities. One of the most notable findings was that, among the over 6,000 respondents who received ambulatory care, nearly half reported being in debt to the facility where they received care. For those who used a hospital emergency room, this figure was even higher; almost two-thirds of these respondents reported being in debt. Moreover, about one quarter of those with unpaid medical bills said their debt would deter them from seeking care at the same facility in the future.[1] Based on these findings, The Access Project has continued to work with community organizations across the country to learn more about the extent, sources, and consequences of medical debt for both uninsured and insured people.[2]

This issue brief provides background on the extent and consequences of medical debt generally, and on the context for investigating this issue in Massachusetts. It also presents the results of a survey of users of two community health centers in Massachusetts that gathered information about the extent of medical debt for users of safety-net facilities in the state, and the impact of this debt on their health and financial well being. Findings from the survey indicate that Massachusetts residents, both uninsured and insured, do experience and suffer serious consequences from medical debt, which affects their ability to get needed health care as well as their housing, employment, and general financial security.

THE PROBLEM OF MEDICAL DEBT

In the last few years, a number of trends have converged to significantly increase the numbers of both the uninsured and the underinsured. Health care costs have risen at double-digit rates, making care less affordable for everyone. Rising unemployment has caused many to lose coverage. For those who remain in the work force, some employers have dropped coverage because of cost, while others have shifted more of the costs to their employees in the form of higher premiums, co-payments, and deductibles.[3] These changes force some individuals to drop coverage because they can no longer afford the premiums and others to face continuously increasing out-of-pocket expenses. Finally, faced with serious budget shortfalls resulting from tax cuts coupled with economic recession, most states, including Massachusetts, have made significant cuts in eligibility or benefits in their Medicaid and other health coverage programs.[4]

Despite these developments, most people in Massachusetts believe that the uninsured in the state are able to access health care, albeit of lower quality than the care insured people receive. In a 2003 survey of Massachusetts residents, 65 percent of respondents thought the uninsured are still able to get medical care, although only 29 percent thought this care was as good as the care received by an "average insured person."[5]

In fact, both national and state data show that the uninsured and, increasingly, the underinsured struggle with paying medical bills, and that cost is often a deterrent to getting needed care. A 2002 national survey reported that almost one in five families, including 15 percent of those with insurance, had problems paying medical bills. The vast majority (86%) of those who had problems paying medical bills said the bills were a serious problem for their families.[6] In the 2003 Massachusetts survey, 28 percent of those who had been uninsured at some time in the previous year and nine percent of those who had been continuously insured reported serious problems paying medical bills.[7]

It is well documented that the uninsured are more likely to delay or forgo care because of cost than those with insurance. In 2003, 28 percent of uninsured Massachusetts residents reported forgoing needed care due to cost. However, as insurers and employers increasingly shift health care costs to consumers, the underinsured are also affected. In the Massachusetts survey, seven percent of the insured reported forgoing needed care because of the expense,[8] while a recent national study showed that sharp increases in co-payments for prescription medications have caused some insured people to stop taking their medications altogether.[9] Even those not yet affected express concern about how they will pay for medical care in the future. More than a third (36%) of Massachusetts residents said they were worried that they might not be able to get the care they need in the next six months because they could not afford it, and about a third (32%) worried that they might lose their health coverage in that period.[10]

Along with reducing access to care, medical expenses often drive families into debt, with consequences for their overall economic security. One national study reported that nearly half of all personal bankruptcies result from health problems or large medical bills.[11] Another reported that more than one-quarter of families in which one or more members were uninsured said they had to "change their way of life significantly" to pay medical bills, a figure that rose to nearly 40 percent when all family members were uninsured.[12] In a report on the findings from interviews with low-income people with medical debt in three communities (Champaign, Illinois; Miami, Florida; and Alexandria, Virginia), The Access Project found that in addition to reducing access to care, medical

debt seriously affected people's ability to access credit, save money, and pay for daily necessities. Not surprisingly, the debt also caused people to experience great stress and anxiety.[13]

At some hospitals, aggressive billing and collections practices exacerbate these problems. Reports on charity care policies and collections practices at Yale-New Haven Hospital in Connecticut led to a series of articles in the *Wall Street Journal.* The *Journal* articles, as well as articles in other newspapers across the country, have detailed cases in Connecticut and elsewhere illustrating the devastating effects of large medical bills and harsh collections practices. These included cases in which people eligible for free or reduced-price care were not informed about programs and were hounded by collection agencies, were charged high interest, had wages garnisheed and property attached, were threatened with foreclosures, and were even put in jail.[14] Additionally, reports on hospital pricing policies in California, Florida and Illinois and lawsuits against the Tenet Healthcare Corporation and HCA[15] have highlighted the paradoxical situation in which the uninsured—those least likely to be able to afford care—are often expected to pay significantly more for the same services than the insured, who have access to steep discounts set by the government or negotiated by their insurers.

THE MASSACHUSETTS CONTEXT

Through the efforts of farsighted policy makers and advocates, Massachusetts has created a relatively strong safety net. A variety of federal and state programs, such as MassHealth (Medicaid) and the Children's Medical Security Plan, provide coverage to people who would otherwise probably be uninsured. Between 1990 and 1998, the percentage of MassHealth enrollees in the state grew significantly, from 8.4 percent to 11.9 percent of the population, due to eligibility expansions and improved outreach. In 1997, policy changes such as the initiation of the Children's Health Insurance Program (CHIP) raised the Massachusetts Medicaid enrollment rate above the national average for the first time in the decade.[16] Community health centers, whose mission is to treat people regardless of their ability to pay, are also available sources of care, at least in some parts of the state.

Massachusetts is also unusual in having an Uncompensated Care Pool that reimburses hospitals and community health centers for a portion of the uncompensated care that they provide. Patients with family incomes up to 400 percent of the federal poverty line are eligible to have at least some of the costs of their care covered by the Pool. In fiscal year 2002, hospitals submitted claims to the Pool for over $705 million in charges.[17] Not all of this total represents medical debt averted, but it does give a

sense of the magnitude of potential medical debt in the absence of adequate and transparent charity care policies and a public mechanism to reimburse providers for some of their uncompensated costs.

The Uncompensated Care Pool also acts as a safeguard against medical debt through the regulations governing its administration.[18] These regulations codify a statewide income standard for charity care in hospitals and community health centers, mandate the use of a standard charity care application form, and require providers to notify patients of the availability of free care through signs in appropriate languages and on all bills and written collection actions. They also require that providers' written credit and collection policies include specific content, set out rules defining categories of patients exempt from collection action, and set allowable parameters for deposits and payment plans. Additionally, the regulations require providers to screen patients for eligibility in other public programs, such as MassHealth, thus making information about these programs an integral part of the intake process. (It should be noted, however, that these regulations only govern providers who receive reimbursement from the Pool—hospitals and community health centers. This standardized system of charity care does not include most physicians, dentists and prescription drugs, in addition to many other less costly types of health care.)

While policies such as the Uncompensated Care Pool and expansion of public programs have been extremely important in helping state residents deal with problems related to un- and underinsurance, the trends of rising health care costs and state revenue shortfalls that the rest of the country has experienced are being felt in Massachusetts as well. Cuts to MassHealth's state-funded program for legal immigrants have eliminated coverage for about 10,000 adults, while enrollment caps in its CommonHealth program will reduce access to care for the disabled. In fact, between August of 2002 and December of 2003, enrollment in MassHealth dropped by over 65,000.[19] Even for those who retain MassHealth coverage, benefit cuts, such as the elimination of dental benefits for adults, and increased cost sharing are also likely to reduce access to care. In addition, reduced eligibility and enrollment caps for the HIV Waiver program will keep many people with HIV from receiving benefits, while underfunding of the Children's Medical Security Plan (CMSP) and increased monthly premiums for CMSP and MassHealth will affect thousands of children in the state.

The FY2004 Massachusetts budget also included significant current and future changes to the Uncompensated Care Pool. In past years, reimbursement from the Pool was based on the amount of uncompensated care hospitals actually delivered. In the current year, however, hospitals will be paid a fixed amount based on projected "low

income patient care costs," which may create a disincentive for them to provide charity care. The amount of Pool resources available to community health centers is capped at $28 million. The total revenue available to hospitals is $380 million, which, according to state projections, will be $78 million below hospitals' aggregate costs for providing free care. And, for the future, the budget law directs the Secretary of Health and Human Services to develop a new program that will replace the Uncompensated Care Pool.[20] While the regulatory safeguards against medical debt remain in place for now, these new provisions suggest the possibility of increasing levels of medical debt in the near future.

ABOUT THIS STUDY

Perhaps because of the existence of the Uncompensated Care Pool in Massachusetts, discussions about rising health care costs and the costs of uncompensated care tend to focus on their impact on institutions that serve the uninsured, such as hospitals and health centers, or on taxpayers generally, rather than on the uninsured and underinsured themselves.

This study looks at the effects of these forces, and resulting medical debt, on the people who actually receive medical care. It reports on the results of a survey that gathered information about the extent of medical debt and its consequences for users of two community health centers in Massachusetts: the Codman Square Health Center, which is located in an inner-city neighborhood in Boston, and the Lynn Community Health Center, which is located in an older manufacturing town about 10 miles north of Boston. We surveyed community health center users not because of debt they may have from these facilities, but because they represent a group of people who use parts of the state's safety net for their health care. The survey asked respondents about whether they had unpaid medical bills from any sources, including hospitals, doctors, pharmacies, and ambulance services. For those with unpaid bills, the survey also asked respondents about the consequences of this debt for themselves and their families.

The survey results show that medical debt is a serious problem even for clients of these safety-net facilities, both uninsured and insured, and that the debt can affect people's access to health care and their economic well being. Of the survey's 342 respondents, more than four in ten (41%) reported having medical debt. The debt negatively affected people's health seeking behavior—almost six in ten of those with debt (59%) said they had needed but delayed getting care because of unpaid medical bills. In addition, the debt made it harder for them to achieve economic

self-sufficiency. Half of those respondents who had medical debt said the debt made it difficult for them to get bank loans and other forms of credit, while 44 percent said they experienced housing problems, such as difficulty paying their rent or mortgage or having to move.

II. METHODS

To gather information about medical debt in Massachusetts, we surveyed clients at two community health centers (CHCs) in the Boston area. This study asked respondents about debt that resulted from receiving medical care from *all* sources.

The study used the methods of community-based participatory research, which emphasizes collaboration among community members, organizational representatives and researchers in all aspects of the research project. The Access Project, in collaboration with researchers at Brandeis University, partnered with community groups at both of the study sites, and involved members of these groups in planning and conducting the surveys. In Lynn, our partners were the Lynn Health Task Force and Lynn Community Health Center. In Dorchester, we partnered with the Civic Health Institute and the Codman Square Health Center.

STUDY SAMPLE AND DATA COLLECTION

A written survey was administered to users accessing care at both study sites. Participation was strictly voluntary and anonymous. At the Codman Square Health Center, surveys were conducted in English and Haitian Creole. At the Lynn Community Health Center, they were conducted in English and Spanish. The surveys were conducted over a two-week period in July and August of 2003. The final sample consisted of 342 respondents, 136 at Codman Square and 206 at Lynn.

STUDY LIMITATIONS

Several limitations should be noted when interpreting the results of this study. First, the survey depended on the voluntary participation of patients using the facility. Participants were not systematically sampled from among all users, and thus may not represent all users of these CHCs.[21] In addition, only two CHCs participated in the study. While these CHCs are diverse—one is located in Boston and affiliated with a major teaching hospital and the other in a small city affiliated with a community hospital—because of the limited sample, it is not known to what degree the results can be generalized to all CHC users in the state.

Second, the survey relies on respondents' accurate self-reporting; no attempt was made to independently verify the answers. Important topics for future research would include whether medical debt tends to be associated with specific health events or health care settings. Third, the sample consists of respondents who were seeking care, so it did not include people who may be deterred from seeking any health care services because of medical debt. This is also a topic of future inquiry.

III. KEY FINDINGS

This section highlights the key findings of the survey. The complete results of the survey are presented in Appendix A, and the survey instrument in Appendix B.

RESPONDENTS WITH DEBT

Of the 342 health center users surveyed, 41% (142 respondents) reported having medical debt.

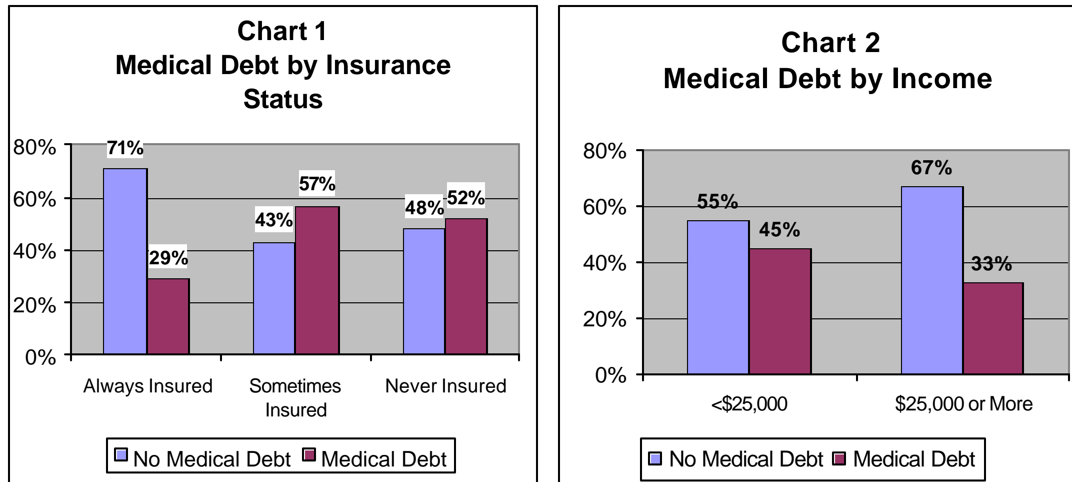
DEMOGRAPHICS

The typical respondent in our sample was a non-White, single female between 22 and 44 years of age. She had, on average, about two children, though one quarter of our sample (23%) had no children and almost one third (30%) had three or more children. More than half of our sample was employed (53%), but mainly in relatively low wage jobs: three quarters (73%) have annual household incomes less than $25,000. We asked respondents to report on their insurance status during the prior year: half (51%) indicated they were continuously insured, one third (32%) that they were insured for part of the year, and about one fifth (17%) that they had no coverage during the past year.

We compared the sub-set of respondents who reported having medical debt to the entire sample to determine if certain types of CHC users are more vulnerable to burdensome medical debt than others. Respondents with and without medical debt were demographically similar, but those with debt were more likely to be unemployed, to report no or sporadic insurance coverage, and to have lower incomes.

While these overall patterns reflect the particular challenge very poor, uninsured households face in paying for health care, it is important to underscore that having insurance and relatively higher incomes does not always protect against debt. Almost three of ten (29%) respondents who were continuously insured over the past year reported having medical

debt (Chart 1). This finding is consistent with recent studies that report an increase in underinsured Americans.[22] One third (33%) of respondents with incomes of $25,000 and above had debt as well (Chart 2).



AMOUNT, SOURCES, AND REASONS FOR DEBT

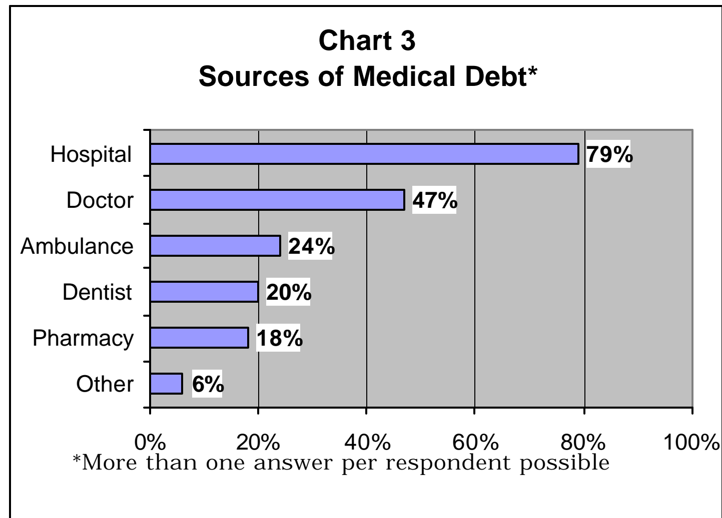
Respondents reporting medical debt owed, on average, about $2,500 in medical expenses, though the range within the sample was substantial; some households owed as much as $20,000 while others owed as little as $25 (Table 1). However, the impact of the debt must be considered in the context of a family's overall income. For a household with an annual income of less than $10,000 (or less than $833 a month), a $2,044 medical bill (the average medical debt for this group) can be a tremendous burden.

Table 1

Amount of Debt by Income

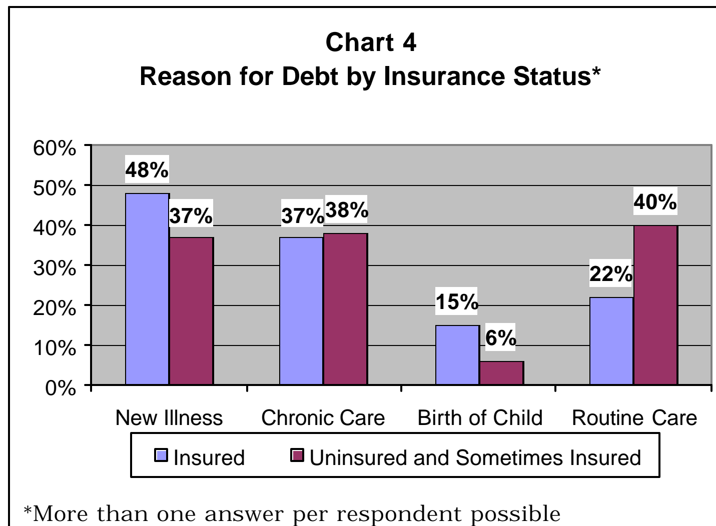
	Income Categories			
	< $10,000	**$10-24,999**	**$25-34,999**	**> $34,999**
	Sample=51	Sample=35	Sample=15	Sample=8
Mean	$2,044	$3,055	$1,794	$5,612
Range				
Minimum	$25	$80	$200	$400
Maximum	$12,000	$20,000	$6,000	$20,000
Median	$1,000	$1,000	$1,000	$2,000

Respondents with medical debt most frequently mentioned hospitals as a source of their debt, though other provider types were identified as well, including doctors, dentists, pharmacy, and ambulance services (Chart 3). With respect to hospital debt, further research is needed to determine whether this debt is primarily for services covered by the Uncompensated Care Pool, or for services related to a hospital stay that are not covered by the Pool, such as services provided by physicians who are not hospital employees.



We asked respondents about the reason for their debt. Respondents with debt reported a variety of reasons, including a new illness (38%), a chronic illness (36%), and routine health care (30%), such as pediatric or dental care.

We looked at the reasons for the debt in relationship to insurance status. Uninsured respondents with debt were almost twice as likely as the insured with debt to say their medical bills resulted from routine health care. Nearly half (48%) of insured respondents had outstanding bills from a new illness. The uninsured and the insured were equally likely to report chronic conditions as sources of medical debt (Chart 4, page 18).

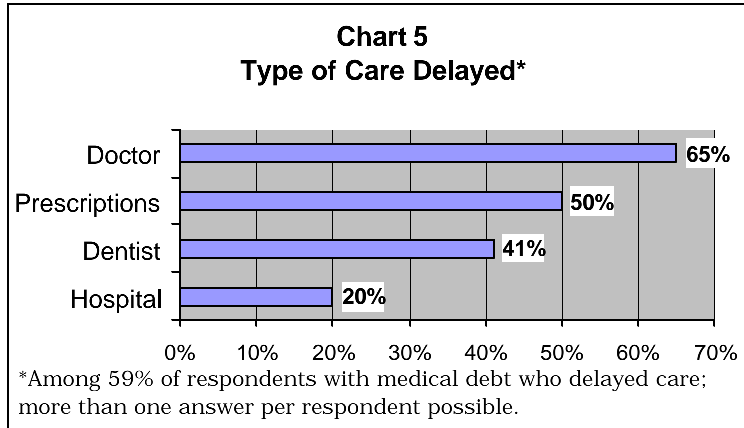


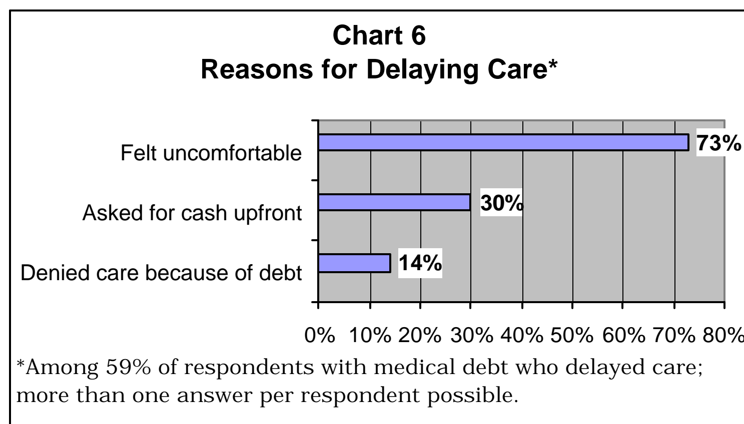
*More than one answer per respondent possible

CONSEQUENCES OF MEDICAL DEBT

Households may experience a number of adverse consequences because of medical debt related to their ability both to access health services and to pay for the expenses of daily living. Our findings are disturbing in this regard and consistent with what we have observed in other communities across the country.

Of the respondents with medical debt, well over half (59%) reported that they needed but delayed getting health care because of their unpaid medical bills. Respondents said they delayed going to the doctor, filling prescriptions, getting dental care, and going to the hospital (Chart 5, page 19). When asked why they delayed getting these needed services, most respondents indicated it was because they felt uncomfortable because they owed money, although some also reported that they were asked to pay cash upfront, and others that they were denied care because of their unpaid bills (Chart 6, page 19).





For many respondents, having medical debt appears to undermine efforts to achieve economic self-sufficiency. For over half of those with medical debt (56% of our sample), the debt is at least partially the result of a medical condition that limits their ability to work and earn income. Over half also indicated that having medical debt made it harder for them to make ends meet: some needed to borrow from friends and family (53%), while others reported having to use credit cards (43%) or savings (54%) for daily needs.

Additionally, over half of the respondents with medical debt (53%) reported that it caused them housing problems, including being turned down from renting a house or apartment, and having difficulty paying the rent or mortgage. For over one third (39%) of respondents with medical debt, employment effects were reported as well, including having to increase work hours and being denied a job because of bad credit (Table 2, page 20). (Some, but not all, health care providers report bad debt to credit bureaus.)

Table 2

Housing and Employment Effects of Medical Debt

	% of sample*
Debt Contributes to Housing Problems	
Yes	53%
No or N/A	47%
Types of Housing Effects	
Turned down from renting house or apartment	43%
Difficulty paying rent or mortgage	79%
Forced to move	34%
Lien on property	9%
Debt Contributes to Employment Problems	
Yes	39%
No or N/A	61%
Employment Effects	
Wages withheld	11%
Increased work hours	70%
Denied a job because of bad credit	49%
File bankruptcy	11%
Other	11%

*Among respondents who have medical debt

Ironically, these effects may be exacerbated when people delay care *because* of unpaid medical bills. Untreated conditions can ultimately require more expensive care, thus exposing patients to even greater financial burdens.

PROVIDER BEHAVIOR

A final set of questions asked respondents about whether their providers assisted them with out-of-pocket medical expenses they could not afford to pay, as well as how aggressively providers pursued collection of the debt. Over two thirds of the respondents with debt (67%) reported that providers offered some type of assistance, mainly in the form of telling them about the availability of free care and public assistance. Nevertheless, many respondents still ended up with medical debt, presumably due to ineligibility, incomplete coverage, or other access barriers to enrolling in these programs.

With respect to provider collection practices, almost two thirds of the respondents with medical debt reported that they had been contacted by a collection agency about the debt. A smaller percentage (16%) indicated they had been sued in small claims court because of their medical bills.

IV. RECOMMENDATIONS AND AREAS FOR FURTHER RESEARCH

These findings show that, in spite of the state's traditionally strong safety net, some Massachusetts residents are still incurring significant debt as a result of obtaining medical services, and this debt affects both their access to care and their overall economic security. The high percentage of these respondents who reported delaying care because they "felt uncomfortable" about the debt (78%) indicates that many people would like to pay these bills but don't have sufficient resources. The results also indicate that medical debt is a widespread problem. While uninsured people in the survey disproportionately reported medical debt, three out of ten insured respondents reported medical debt as well. Similarly, while the lowest income people were more likely to report medical debt, a third of the respondents with annual incomes above $25,000 also were in debt because of medical bills.

RECOMMENDATIONS

Given rising health care costs and the cuts to public health coverage programs, the problem of medical debt in Massachusetts is almost certain to worsen. In light of the findings, we make the following recommendations.

1. **Policy makers need to consider both the health-related and economic effects of rising health care costs and the lack of adequate health insurance on individuals and their families, as well as on institutions, when trying to craft solutions to these growing problems.**

   The survey results undermine the common perception that it is primarily provider institutions and the taxpayers who bear the costs of care for the un- and underinsured. Despite our safety net, it is clear that many individuals in Massachusetts who need care but have limited resources are forced to shoulder a financial burden that adds to the burden of illness and causes adverse consequences for themselves and their families. In particular, the high rate of hospital debt among survey respondents suggests that the Uncompensated Care Pool, while an important resource, still leaves many uninsured people who get hospital care vulnerable to serious financial burdens.

   In this light, policy makers need to reconsider cuts in public programs, such as MassHealth, that have left many more people without health care coverage, as well as policies that place more of a

financial burden on those who remain eligible, for example through increased premiums and co-payments.

2. **Policy makers must ensure that changes to the Uncompensated Care Pool do not lead to increased medical debt among those currently eligible for charity care funded by the Pool, and that current regulations are consistently implemented.**

   In a change from previous years, the Pool this year provides fixed amounts to facilities for reimbursement of charity care, rather than tying reimbursement to the actual amount of charity care delivered. This provides a potential disincentive for hospitals to provide such care. It is important to monitor whether this change does in fact lead to a reduced likelihood of people applying for and/or receiving free or partial free care.

   The high percentage of uninsured survey respondents with hospital debt also suggests that some people who are eligible for coverage under the Pool may not be receiving it. The American Hospital Association recently released guidelines calling on all hospitals to publish clear charity care policies and communicate them to patients in an easily understandable way.[23] Massachusetts must also ensure that all patients who qualify for assistance from the Pool know about the program and receive help in applying for it.

   The state is also currently considering replacement of the Uncompensated Care Pool with a new mechanism for financing care for low-income uninsured and underinsured people. The new program should be judged on the extent to which it makes medically necessary care available to people who lack coverage or the means to pay for it.

   In addition, it is imperative that any new system retain and strengthen the consumer protections now included in Uncompensated Care Pool regulations that help prevent medical debt for those who cannot afford to pay for their health care. Requirements regarding eligibility for free care, notification of the availability of assistance, screening for public programs, credit and collection policies, and collection exemptions are all laid out in the regulations. If the Pool is replaced and the regulations rewritten, these provisions must not be lost.

Areas for Further Research

The findings of the survey also suggest a number of areas where further research would be valuable.

1. **Conduct additional research to learn why, in spite of the fact that providers do a relatively good job of informing people about charity care, almost eight in ten respondents with medical debt reported owing money to hospitals.**

   Further research is needed to understand the sources of this debt for the uninsured. Policy makers need to know more about whether hospital debt results from costs not covered by the Uncompensated Care Pool, such as services from doctors who provide care to hospital patients but are not hospital employees, from people's failure to apply to the Pool, from ineligibility for charity care programs, or from barriers that make applying for free care difficult.

2. **Conduct additional research into why people with health insurance have serious medical debt.**

   A primary function of health insurance is to ensure that people who need medical care can access it without jeopardizing their financial resources. The significant percentage of respondents with insurance who reported medical debt raises questions about why their insurance failed to provide such protection. It is important to determine whether debt among insured people results primarily from high co-payments and deductibles, limited benefits, or bureaucratic obstacles created by insurers and providers that may result in non-payment of covered services. For example, people may receive bills that are sent to collection agencies and affect their credit rating even while their insurer and provider are trying to resolve issues related to coverage. Findings from such a study could inform policy making to alleviate some of the problems related to medical debt that currently affect many who do have insurance.

3. **Learn more about medical debt from sources other than hospitals, and craft policies designed to help patients deal with this debt.**

   Along with hospitals, key sources of debt identified by survey respondents included doctors (reported by 42% of those with debt), dentists (20%), ambulance services (27%), and pharmacies (24%). As mentioned previously, the Uncompensated Care Pool does not cover most of these services. Depending on the results of such research, responses could include legislation or guidelines on the provision of charity care by non-hospital providers and limits on the types of

collection activities providers can initiate against low-income un- or underinsured people. Prohibiting providers or bill collectors from reporting medical debt to credit reporting agencies might also mitigate some of the economic consequences of accruing such debt.

V. CONCLUSION

The problems related to medical debt reflect a range of problems in our current health care system—most notably its inability to control costs and to provide affordable care to everyone. Yet it is a problem that is often “under the radar.” Hospitals frequently cite the amounts of uncompensated care that they provide, in which they include receivables written off as bad debt. The fact that this debt, even after it is “written off,” can still create serious problems for those without the resources to pay for their care is less often mentioned.

In the long run, the only real solution to these problems is the creation of a system of universal coverage with appropriate cost containment measures. In the short run, however, people need more immediate help. Some of the solutions are clear—for example the expansion of public and private coverage programs and the maintenance of charity care programs with appropriate outreach to those who may benefit. Further research into the causes of medical debt will suggest other measures that may also help protect people from the health and economic consequences of being unlucky enough to get sick.

APPENDIX A: DATA TABLES

Table 1. Comparison of Respondents With and Without Medical Debt

	Medical Debt (Sample = 142)	No Medical Debt (Sample = 200)	Total (Sample = 342)
	Number of respondents (fraction of total)		
1. Gender			
Male	49 (.35)	76 (.38)	125 (.37)
Female	92 (.65)	123 (.62)	215 (.63)
Total	141 (1.0)	199 (1.0)	340 (1.0)
2. Age			
18-24	23 (.16)	35 (.18)	58 (.17)
25-44	69 (.49)	102 (.52)	171 (.51)
45-64	42 (.30)	45 (23)	87 (.26)
Over 64	7 (.05)	13 (.07)	20 (.06)
Total	141 (1.0)	194 (1.0)	336 (1.0)
*3. Marital Status***			
Married	48 (.34)	66 (.33)	114 (.34)
Divorced/Widowed	22 (.16)	23 (.12)	45 (.13)
Single	54 (.38)	100 (.50)	154 (.45)
Separated	17 (.12)	10 (.05)	27 (.08)
Total	141 (1.0)	199 (1.0)	340 (1.0)
4. Race/Ethnicity			
White	33 (.24)	46 (.24)	79 (.24)
Black	60 (.43)	71 (.37)	131 (.39)
NA/API[1]	6 (.04)	11 (.05)	17 (.05)
Hispanic	41 (.29)	66(.34)	107 (.32)
Total	140 (1.0)	194 (1.0)	334 (1.0)
5. Household Size			
1	24 (.17)	45 (.23)	69 (.20)
2 or 3	55 (.39)	71 (.35)	126 (.37)
4 or 5	48 (.34)	63 (.31)	111 (.33)
6 or more	14 (.10)	21 (.11)	35 (.10)
Total	142 (1.0)	199 (1.0)	341 (1.0)

1. Native American or Asian/Pacific Islander.
** Indicates significant difference ($p < .05$) between “medical debt” and “no medical debt” groups.

Table 1 (cont.)

	Medical Debt (Sample = 142)	No Medical Debt (Sample = 200)	Total (Sample = 342)
6. Children	Number of respondents (fraction of total)		
None	28 (.20)	48 (.25)	76 (.23)
1	32 (.23)	42 (.22)	74 (.22)
2	36 (.25)	48 (.25)	84 (.25)
3 or more	45 (.32)	55 (.28)	100 (.30)
Total	141 (1.0)	193 (1.0)	334 (1.0)
7. Employment **			
Employed	54 (.39)	103 (.53)	157 (.47)
Unemployed	86 (.61)	90 (.47)	176 (.53)
Total	140 (1.0)	193 (1.0)	333 (1.0)
8. Income **			
Less than $25,000	108 (.79)	130 (.69)	238 (.73)
$25,000 and higher	29 (.21)	59 (.31)	88 (.27)
Total	137 (1.0)	189 (1.0)	326 (1.0)
9. Insurance **			
Always covered	51 (.36)	124 (.62)	175 (.51)
Sometimes covered	61 (.43)	47 (.24)	108 (.32)
Never covered	30 (.21)	28 (.14)	58 (.17)
Total	142 (1.0)	199 (1.0)	341 (1.0)

** Indicates significant difference ($p < .05$) between "medical debt" and "no medical debt" groups.

Table 2. Debt Amount

(Based on respondents with medical debt who answered survey question = 109)

	Income Categories			
	< $10,000	**$10-24,999**	**$25-34,999**	**> $34,999**
	Sample=51	Sample=35	Sample=15	Sample=8
Mean	$2,044	$3,055	$1,794	$5,612
Range				
Minimum	$25	$80	$200	$400
Maximum	$12,000	$20,000	$6,000	$20,000
Median	$1,000	$1,000	$1,000	$2,000

Table 3. Sources and Reasons for Medical Debt
(Based on respondents with medical debt who answered question)

	Number of Respondents	% of Sample
1. Sources of Medical Debt	**136**	
Hospital	107	79%
Doctor	64	47%
Dentist	27	20%
Pharmacy/Drug Store	25	18%
Ambulance services	33	24%
Other (clinic, health center, other)	8	6%
(**Note:** more than one answer per respondent possible)		
2. Reason for Debt	**135**	
New illness	51	38%
Chronic illness	48	36%
Birth of child	12	9%
Routine health care	41	30%
Other (cancer, x-rays, other[1])	8	6%
(**Note:** more than one answer per respondent possible)		
3. Provider Offers Some Type of Assistance		
Yes	88	67%
No	43	33%
Total	131	100%
3a. Type of Assistance	**88**	
Offer to discount bill	7	8%
Inform about free care/public assistance	60	68%
Suggest a payment plan	28	32%
Suggest you take out a loan	2	2%
(**Note:** more than one answer per respondent possible)		

1. "Other" responses indicate question misunderstood by some respondents (e.g. free care pending, hospital failed to submit, bill after deadline, no Medicare, non-referral)

Table 4. Housing, Employment and Health Care Effects
(Based on respondents with medical debt who answered question)

	Number of Respondents	% of Sample
1. Debt Contributes to Housing Problems		
Yes	56	53%
No or N/A	49	47%
Total	105	100%
1a. Types of Housing Effects	**56**	
Turned down from renting house or apartment	24	43%
Difficulty paying rent or mortgage	44	79%
Forced to move	19	34%
Lien on property	5	9%
(**Note:** more than one answer per respondent possible)		
2. Debt Contributes to Employment Problems		
Yes	37	39%
No	59	61%
Total	96	100%
2a. Employment Effects	**37**	
Wages withheld	4	11%
Increased work hours	26	70%
Denied a job because of bad credit	18	49%
Filed for bankruptcy	4	11%
Other (lost job, a lot of worries, miscellaneous other)	4	11%
(**Note:** more than one answer per respondent possible)		
3. Delayed Care Due to Debt		
Yes	78	59%
No	54	41%
Total	132	100%
3a. Type of Care Delayed	**78**	
Doctor	53	68%
Hospital	16	21%
Prescriptions	41	53%
Dental	34	44%
(**Note:** more than one answer per respondent possible)		
3b. Reason Delayed Care	**78**	
Asked to pay cash upfront	27	35%
Denied care access	11	14%
Feel uncomfortable	57	73%
Other (afraid to incur more expenses, miscellaneous other)	11	14%
(**Note:** more than one answer per respondent possible)		

Table 4 (cont.)

	Number of Respondents	% of Sample
4. Made Ends Meet with Savings, Credit, Family and Friends		
Yes	72	56%
No	57	44%
Total	129	100%
4a. Type of Support Used	**72**	
Savings	39	54%
Credit cards	31	43%
Family and friends	38	53%
(**Note:** more than one answer per respondent possible)		
5. Harder to Get Loans and Credit		
Yes	62	50%
No	61	50%
Total	123	100%
5a. If "Yes", how did debt make it harder?	**62**	
Denied a credit card	48	96%
Denied loan	38	75%
(**Note:** more than one answer per respondent possible)		
6. Sued in Small Claims		
Yes	17	16%
No	91	84%
Total	108	100%
7. Contacted by Collection Agency		
Yes	79	64%
No	45	36%
Total	124	100%
8. Income Loss Due to Illness/Injury		
Yes	70	56%
No	54	44%
Total	124	100%

Appendix B: Survey Questionnaire

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

A. MEDICAL DEBT

1. Do you currently 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.

2. What is your gender? ☐ Male ☐ Female

3. What is your age?
☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ over 64

4. What is your marital status?
☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

5. What is your race/ethnicity (check all that apply)?
☐ White ☐ Black ☐ Native American ☐ Asian/Pacific Islander ☐ Hispanic

6. Please specify your country of origin ______________________________

7. What is your household size? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

8. How many children do you have?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More than 4

9. Are you currently: ☐ Employed ☐ Unemployed

10. Which best describes your household's annual income from all sources?
☐ Less than $10,000 ☐ $25,000 - $34,999
☐ $10,000 - $24,999 ☐ $35,000 or more

11. 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 coverage through your employer, MassHealth, and Medicare, but does NOT include the Free Care Pool or CareNet.

C. ABOUT YOUR MEDICAL BILLS

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

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

☐ Hospital ☐ Doctor ☐ Dentist ☐ Pharmacy/Drug Store

☐ Ambulance service ☐ Other________________

13. Which best describes the reason you 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) ____________________________________

14. 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 ☐ Inform you about public assistance

☐ Suggest a payment plan ☐ Suggest you take out a loan to help pay for your bill

☐ Other (describe) ______________________ ☐ No assistance offered

15. Please estimate about how much you owe in medical bills: $______________

D. YOUR QUALITY OF LIFE

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

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

	Yes	*No*	*Not Applicable*
a. Turned down from renting a house or apartment	________Y	________N	________N/A
b. Difficulty paying rent or mortgage	________Y	________N	________N/A
c. Forced to move	________Y	________N	________N/A
d. A lien placed on your property	________Y	________N	________N/A
e. Other (describe) ________________________________			

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

	Yes	*No*	*Not Applicable*
a. Wages withheld	________Y	________N	________N/A
b. Increased work hours	________Y	________N	________N/A
c. Denied a job because of poor credit	________Y	________N	________N/A
d. Filed for bankruptcy	________Y	________N	________N/A
e. Other (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.

18. Since owing money for medical bills, have you 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
- [ ] Other (describe) ____________
- [ ] No, I have not delayed getting health care

19. Since owing money for medical bills, have you or a household 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
- [ ] You feel uncomfortable because you owe money
- [ ] No, I have not delayed getting health care
- [ ] Other (describe) ____

20. 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 following to make ends meet
- [ ] Other (describe)______________________

21. Has owing money for medical bills made it harder to get loans or credit? [ ] No [ ] Yes

21a. 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) ______________________________________

22. Because of the money you owe for medical bills, have you:

a. Been sued in small claims court? [ ] No [ ] Yes *(Who sued you?)*_____________________

b. Been contacted by a collection agency? [ ] No [ ] Yes *(For what bill?)*______________________

23. Did loss of income due to illness or injury contribute to your overall debt problem?

[ ] No [ ] Yes

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

ENDNOTES

[1] D. Andrulis, L. Duchon, C. Pryor, N. Goodman, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?*, The Access Project, January 2003.

[2] For additional Access Project reports on medical debt, see D. Gurewich, R. Seifert, J. Prottas, *The Consequences of Medical Debt: Evidence from Three Communities*, The Access Project, February 2003, and C. Pryor, R. Seifert, D. Gurewich, L. Oblak, B. Rosman, and J. Prottas, *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt*, The Commonwealth Fund, June 2003.

[3] See, for example, *The Growing Share of Uninsured Workers Employed by Large Firms*, S. Glied, J. M. Lambrew, and S. Little, The Commonwealth Fund, October 2003, and *Employer Health Benefits: 2003 Annual Survey,* Kaiser Family Foundation and Health Research Educational Trust, September 2003.

[4] See for example V.K. Smith and D. M. Rousseau, *SCHIP Program Enrollment, June 2003 Update*, Kaiser Commission on Medicaid and the Uninsured, December 2003, and L. Ku and S. Nimalendran, *Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs*, Center on Budget and Policy Priorities, December 2003.

[5] R. Blendon, C. DesRoches, E. Raleigh, J. Benson, *The Uninsured in Massachusetts: An Opportunity for Leadership,* Blue Cross Blue Shield of Massachusetts Foundation, October 2003.

[6] National Public Radio, Harvard University Kennedy School of Government, Henry J. Kaiser Family Foundation, *National Survey on Health Care*, Kaiser Family Foundation, 2002.

[7] Blendon, *op.cit.*

[8] *Ibid.*

[9] L. Kowalczyk, "Study: Higher copayments hurt patients," *Boston Globe*, December 4, 2003.

[10] Blendon, *op.cit.*

[11] M.B. Jacoby, T.A. Sullivan, E. Warren, "Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," *76 NYU Law Review,* 375, 2000.

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[13] D. Gurewich et al, *op. cit.*

[14] G. Rollins, *Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices*, Connecticut Center for a New Economy, January 2003. L. Lagnado, "Twenty Years and Still Paying," *Wall Street Journal*, March 13, 2003. L. Lagnado, "Full Price: A Young Woman, An Appendectomy, and a $19,000 Debt," *Wall Street Journal*, March 17, 2003. L. Lagnado, "Hospitals Try Extreme Measures to Collect Their Overdue Debts," *Wall Street Journal*, October 30, 2003.

[15] See for example SEIU Hospital Accountability Project, *Uninsured and Overcharged: How Advocate Health Care Overcharges Chicago Hospital Patients,*" May 2003, and "Target: Medical Bills," *People Magazine*, October 6, 2003.

[16] *Massachusetts Health Care Trends: 1990-1999*, Massachusetts Division of Health Care Finance and Policy, October 2000.

[17] Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool PFY02 Annual Report.* February 2003.

[18] 114.6 CMR 10.

[19] Massachusetts Division of Medical Assistance, *DMA Medicaid Enrollment 12-31-02*, and *DMA Medicaid Enrollment 12-31-03* (spreadsheets).

[20] Massachusetts General Court, Chapter 26 of the Acts of 2003.

[21] A limited comparison of our study sample to all users of our study sites found the following: Respondents in Lynn were similar to all users of the Lynn Community Health Center in terms of gender, age, race, and insurance status. In Codman Square, our sample had a somewhat disproportionate number of users who were aged 25 to 44 years, black, and uninsured.

[22] Institute of Medicine, Committee on the Consequences of Uninsurance, *Coverage Matters: Insurance and Health Care*, Washington, DC: National, Academy Press, 2001.

[23] *Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association*, American Hospital Association, December 17, 2003.