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HOME SICK: HOW MEDICAL DEBT UNDERMINES HOUSING SECURITY*

ROBERT W. SEIFERT**

INTRODUCTION

"Anyone can get health care if they really need it." This is a typical response to the reality of growing numbers of uninsured and inadequately insured people in the United States.[1] Americans believe that a safety net of emergency rooms, free clinics, and other facilities are available to provide care to those without the means to pay for it, so that no one need go entirely without health care services.

This belief is false. A large body of evidence has established that access to health care depends to a great degree on the ability to pay for it, either with insurance or out of one's own pocket. This research has brought to light another consequence of this situation: even when people are able to get care, they usually receive a bill for it, which can wreak subsequent havoc on their finances and access to health care. This report, developed by The Access Project,[2] addresses the effects of medical debt on one important aspect of people's lives—their housing situation.

* This report was initially published under the same title by The Access Project. The author would like to thank Nancy Kohn, Andrew Cohen, and the staff of The Access Project, as well as Jeffrey Prottas and Mathilda Ruwe of Brandeis University. A number of community organizations were instrumental in the production of this survey, including: ACORN chapters in our survey cities; The United Way of Palm Beach County, Florida; ISED Ventures, Making Connections Des Moines, CCI, Home Inc., and the Neighborhood Health Initiative in Des Moines, Iowa; The Community Action Program of Tulsa, Oklahoma; and the Center for Health Law Studies at Saint Louis University School of Law, Jobs with Justice, the Missouri Citizen Education Fund, and the SEIU Missouri State Council in St. Louis, Missouri.

Generous support from the W.K. Kellogg Foundation, the Annie E. Casey Foundation, the Missouri Foundation for Health, and the Quantum Foundation made this project possible.

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1. For example, 55% of people in a national poll said that uninsured people are still able to get the medical care they need from doctors and hospitals. KAISER FAM. FOUND., HEALTH POLL REPORT (July 2001).

2. The Access Project has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those

The Access Project has been exploring the issue of medical debt for several years, since the issue emerged through some of its community-based research as a significant but relatively unremarked barrier to health care.[3] Further examination exposed significant financial consequences of the debt as well.[4] At the same time, community organizations across the country are engaged in these issues at the local and regional levels through their health care advocacy, economic improvement, and community organizing activities. The Access Project joined forces with a number of these groups—ACORN chapters in Bridgeport, CT, Providence, RI, Atlanta, GA, and Phoenix, AZ; The United Way of Palm Beach County, FL; ISED Ventures in Des Moines, IA; the Community Action Project of Tulsa, OK; and the Center for Health Law Studies at the Saint Louis University School of Law—to produce this report.

Findings from the survey corroborate earlier research on the scope and effects of medical debt. We surveyed 1,692 low and moderate income people in seven communities[5] who were filing income tax returns in Volunteer Income Tax Assistance (VITA) sites.[6] Many were eligible to claim the federal Earned Income Tax Credit. Nearly half of these survey respondents said they had medical debt,[7] and debt was reported to a roughly equivalent extent among all ethnic categories and all income ranges captured in the survey.[8] The surveys also reveal a previously unexplored consequence of medical debt—that it affects low-income families' efforts to own, rent, or maintain their homes.[9] Our key findings indicate:

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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. The Access Project's fiscal sponsor is Third Sector New England, a non-profit with more than 40 years of experience in public and community health projects. The Access Project is affiliated with the Heller School for Social Policy and Management at Brandeis University. For more information, visit http://www.accessproject.org.

3. *See* DENNIS ANDRULIS ET AL., ACCESS PROJECT, PAYING FOR HEALTH CARE WHEN YOU'RE UNINSURED: HOW MUCH SUPPORT DOES THE SAFETY NET OFFER? 6 (Jan. 2003), *available at* http://www.accessproject.org/adobe/paying_for_healthcare_when_youre_uninsured.pdf (discussing research methods).

4. ACCESS PROJECT, THE CONSEQUENCES OF MEDICAL DEBT: EVIDENCE FROM THREE COMMUNITIES 18–21 (Feb. 2003), *available at* http://www.accessproject.org/adobe/the_consequences_of_medical_debt.pdf; CAROL PRYOR & DEBORAH GUREWICH, ACCESS PROJECT, GETTING CARE BUT PAYING THE PRICE: HOW MEDICAL DEBT LEAVES MANY IN MASSACHUSETTS FACING TOUGH CHOICES 19–20 (Feb. 2004), *available at* http://www.accessproject.org/adobe/getting_care_but_paying_the_price.pdf.

5. Bridgeport, Connecticut; Des Moines, Iowa; Phoenix, Arizona; Providence, Rhode Island; St. Louis, Missouri; Tulsa, Oklahoma; and West Palm Beach, Florida.

6. *See infra* Section II.

7. *See infra* app. A, tbl. A1.

8. *See infra* app. A, tbl. A3.

9. *See infra* app. A, tbl. A2.

- More than a quarter of respondents with medical debt said that the debt resulted in housing problems such as the inability to qualify for a mortgage, to make mortgage or rent payments, or to secure or maintain a home.
- Respondents whose medical debts appeared on their credit reports were twice as likely to experience housing problems as those whose credit reports did not include medical debts.
- Even relatively small amounts of debt—$500 or less—created housing problems for substantial numbers of people.
- Having health insurance did not sufficiently protect many families from either medical debt or the resulting credit and housing problems.
- Medical debt is "accidental debt" that creates a cascade of consequences that ultimately limit the ability of families with moderate incomes to have a secure place to live.

Section I of this report describes past research on medical debt and its consequences. Section II explains the methodology used to conduct the study. The findings of this study are collected and explained in Section III, and Section IV analyzes the data in order to explore the problems medical debt creates. Finally, we supply recommendations that can mitigate housing problems related to medical debt. The data from this survey is collected in the Appendices.

I. WHAT WE KNEW: PAST RESEARCH ON MEDICAL DEBT

Medical debt is money owed for medical services or products, such as hospital or physician's care, prescription drugs, and ambulance services. It may be money owed directly to the provider of the service, to an agent of the provider, or to another source (such as a credit card or other lender) that may have been used to pay a bill. The debt itself may represent an entire bill or just the portion for which an individual is responsible, such as a copayment or deductible for a service that is covered by insurance. What is common about medical debt is that it is usually involuntarily acquired in pursuit of a service on which a person's well being (and sometimes life) depends, it is usually not planned for, and it is widespread across the population of the United States. This Section of the report sets the context for the new information, particularly concerning housing consequences of medical debt, which we have discovered from our survey.

A. Prevalence of Medical Debt

Numerous studies have confirmed that a large portion of the population of the United States experiences medical debt. These studies looked at the issue both nationally and locally, and the findings are consistent. The

Commonwealth Fund's 2003 Biennial Health Insurance Survey[10] reported that, nationally, about a third (32%) of adults under age 65 had a medical bill problem (they were unable to pay a bill, they were contacted by a collection agency about a medical bill, or they had to change their way of life significantly to pay medical bills) in the past 12 months, and that one in six (16%) had recent or accrued medical debt.[11] Overall, two in five (41%) non-elderly adults had recent medical bill problems or accrued medical debt.[12] The number grows to three in five (60%) for people who were uninsured at any time during the past year.[13] Another recent survey found that one American in five (21%) had a medical bill *currently* overdue.[14] Other national surveys, while not as detailed on the matter of medical debt, found similar numbers of people reporting difficulty paying medical bills.[15]

At the community level, Access Project research has found a comparable level of medical debt. In a survey of uninsured people in 24 communities, 60% of respondents said they needed help paying their medical bills, and nearly half (46%) reported having unpaid bills or being in debt to the facility where they received care.[16] Another study found that nearly 40% of households seeking credit counseling services at an agency in Florida reported that a medical event contributed to their debt problems.[17]

B. *Characteristics of People with Medical Debt*

The widespread incidence of medical debt makes it unsurprising that, while more vulnerable groups are more likely to experience medical debt, all economic and demographic groups are affected. For example, while nearly half (44%) of adults with incomes up to twice the federal poverty level[18] had

10. Michelle M. Doty et al., *Seeing Red: Americans Driven into Debt by Medical Bills*, ISSUE BRIEF (Commonwealth Fund, New York, N.Y.), Aug. 2005, at 1, *available at* http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_ debt.pdf.

11. *Id*. at 2, 3.

12. *Id*. at 3.

13. *Id*.

14. USA TODAY, KAISER FAM. FOUND. & HARVARD SCH. OF PUB. HEALTH, HEALTH CARE COSTS SURVEY: SUMMARY AND CHARTPACK 3 (Aug. 2005), *available at* http://www.kff.org/newsmedia/upload/7371.pdf.

15. *See, e.g.*, NAT'L PUB. RADIO, KAISER FAM. FOUND. & JOHN F. KENNEDY SCH. OF GOV'T, NATIONAL SURVEY ON HEALTH CARE: CHARTPACK, chart 1 (June 2002), *available at* http://www.npr.org/news/specials/healthcarepoll/healthgraphs.pdf.

16. ANDRULIS ET AL., *supra* note 3, at 7, 9.

17. Deborah Gurewich, Jeffrey Prottas, Robert Seifert & Susan Seager, *Medical Debt and Consumer Credit Counseling Services*, 15 J. HEALTH CARE FOR THE POOR & UNDERSERVED 336, 339 (2004).

18. The federal poverty level was $36,800 for a family of four in 2003, when the survey reporting this data was conducted. *See* Annual Update of the HHS Poverty Guidelines, 68 Fed. Reg. 6456, 6457 (Feb. 7, 2003).

medical bill or debt problems, 22% of adults with higher incomes also reported such problems.[19] About half (52%) of African Americans and a third (34%) of Latinos had debt problems, but so did nearly a third (28%) of Whites.[20] More than two in five (43%) adults in poorer health had bill and debt problems, but almost a quarter (23%) of the healthiest people did as well.[21] And as mentioned earlier, three-fifths of people who had been without health insurance at any time in the past year had medical bill and debt problems, but a substantial percentage of people who were continuously insured (35%) did too.[22]

Although uninsured people are the most obvious victims of medical debt, people with health insurance are also at risk. The Commonwealth Fund study found that a majority (62%) of non-elderly adults with medical bill or debt problems were insured at the time the bill was incurred.[23] That finding calls attention to the growing problem of health insurance that does not fulfill its central purpose: to shelter the insured person from excessive financial risk.

The increasing prominence of health plans that require greater contributions from individuals through higher deductibles and copayments means that more insured people—particularly those at the lower end of the income spectrum—will face financial burdens that do not differ greatly from those facing the uninsured. A recent study conservatively estimated that there were about 16 million "underinsured" adults in 2003, in addition to the 45 million uninsured.[24] The access, care, and financial experiences of the underinsured were more similar to those of the uninsured than to those with adequate insurance coverage.[25] The inadequacy of insurance coverage is another theme of this study, as will be discussed later in this report.

C. Effects of Medical Debt

People with medical debt experience effects in terms of both their access to health care and their financial well-being. Nationally, people with medical debt are much more likely than those without to skip a medical treatment or

19. Doty et al., *supra* note 10, at 2, fig. 1.

20. *Id.* at 2.

21. *Id.* at 2–3.

22. *Id.* at 3.

23. *Id.* at 4, fig. 4.

24. Cathy Schoen et al., *Insured But Not Protected: How Many Adults are Underinsured?*, HEALTH AFF., June 14, 2005, at W5-289, W5-293, http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.

25. *Id.* at 296. An "underinsured" adult is defined in this study as one with health insurance whose family out-of-pocket medical expenses represent 10% or more of income or 5% or more of income in low-income families, or whose deductible represents 5% or more of income. *Id.* at 292. It probably underestimates the number of people whose insurance is inadequate because some of the criteria reflect policies that have *actually* failed to protect and not those that *potentially* fail to protect.

follow-up, and they are less likely to fill a prescription, see a specialist when needed, or see a doctor when having a medical problem.[26] Three out of five (60%) people whose medical debt contributed to their need to file bankruptcy went without a needed doctor or dentist visit, and half failed to fill a prescription.[27]

Past community research that The Access Project has done with local partners supports these findings. In a survey of uninsured people in 24 communities, nearly one-quarter of people with unpaid bills said the debts would deter them from seeking care at the same facility in the future.[28] In a study of people with medical debt in two communities in Massachusetts, about three-quarters (73%) of respondents who delayed getting care because of debt said it was because they were uncomfortable about the bills, 30% said they were asked to pay up front, and 14% said they were denied care altogether.[29]

The gamut of financial effects of medical debt runs from nuisance to nightmare. It is typical for a person owing money for medical bills to hear from a collection agency; 21% of *all* non-elderly adults in the Commonwealth Fund survey had been contacted by collection agents about medical bills in the past year.[30] Some debt counselors consider medical providers to be among the most aggressive collectors.[31] Medical debt also inhibits people's ability to accumulate savings and to purchase basic necessities (such as food, heat, rent, or telephone service).[32] Moreover, the consequences of medical debt sometimes extend even further. People who owe medical bills often find themselves in court and subsequently subject to legal judgments that might include wage garnishment and liens on their homes, sometimes leading to foreclosure.[33] In some cases, failure to comply with court ordered repayment

26. Doty et al., *supra* note 10, at 6., fig. 6

27. David U. Himmelstein et al., *Market Watch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5-63, W5-68, http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.

28. ANDRULIS ET AL., *supra* note 3, at 10.

29. PRYOR & GUREWICH, *supra* note 4, at 19, chart 6.

30. Doty et al., *supra* note 10, at 4, fig. 3.

31. Jennifer Steinhauer, *Will Doctors Make Your Credit Sick?*, N.Y. TIMES, Feb. 4, 2001, at B13.

32. RACHEL BANOV, WASH. UNIV. CTR. FOR SOC. DEV., THE EFFECT OF HEALTH INSURANCE ON SAVINGS OUTCOMES IN INDIVIDUAL DEVELOPMENT ACCOUNTS 32 (2005), *available at* http://gwbweb.wustl.edu/csd/Publications/2005/Banov_Research_Report.pdf; Doty et al., *supra* note 10, at 3; Himmelstein et al., *supra* note 27, at 68, exh. 4.

33. GRACE ROLLINS, CONN. CTR. FOR A NEW ECON., UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES 14 (Jan. 2003), *available at* http://www.ctneweconomy.org/Publications/UC.pdf; Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1.

plans have actually landed medical debtors in jail.[34] And medical expenses or lost income due to illness or injury are factors in about half of all personal bankruptcies, about two million people per year.[35]

D. The Motivation for This Study

In exploring the extent and consequences of medical debt with its local partners around the country, Access Project staff have frequently heard about these consequences of medical debt. Another consequence was also commonly related: that medical debt was a barrier to home ownership because it prevented people from qualifying for mortgages.[36] If this is, in fact, a common phenomenon, and if medical debt contributes to other housing difficulties as well, it presents a serious challenge both to people who work hard to provide for their families and improve their economic standing—home ownership is a major engine of wealth accumulation for middle class families—and to policy makers who want to strengthen communities by promoting such behavior. The remainder of this report explores how medical debt influences families' housing and overall economic stability.

II. METHODS

The surveys were conducted in eight cities: Atlanta, GA; Bridgeport, CT; Des Moines, IA; Phoenix, AZ;[37] Providence, RI; Saint Louis, MO; Tulsa, OK; and West Palm Beach, FL. The primary venues for conducting the surveys were VITA sites either run by or associated with the local research partner participating in this project. VITA programs offer free tax help to people whose incomes were $36,000 or less in 2004.[38] They are generally located at community and neighborhood centers, libraries, schools, shopping malls, and other convenient locations. In some instances,[39] surveys were done at more than one VITA site. In four sites,[40] field organizers for ACORN—the local research partner in these locations—conducted some surveys by going door-to-door in the community.[41] The surveys not collected at VITA sites have been excluded from the aggregate data reported here, and the analysis of the

34. Lucette Lagnado, *Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debts*, WALL ST. J., Oct. 30, 2003, at A1.

35. Himmelstein et al., *supra* note 27, at 66, 67, exh. 2.

36. *See infra* app. A, tbl. A2.

37. Actual surveying was done in Mesa and Glendale, communities in the Phoenix metropolitan area.

38. *See* Internal Revenue Service, Free Tax Return Preparation For You by Volunteers, http://www.irs.gov/individuals/article/0,,id=107626,00.html (last visited Jan. 8, 2007).

39. St. Louis, Des Moines, Tulsa, and West Palm Beach.

40. Atlanta, Bridgeport, Phoenix, and Providence.

41. All of the Atlanta surveys were collected in this fashion.

aggregate data that follows encompasses seven of the eight cities.[42] The Section that reports site-specific findings includes all of the data.[43] A total of 2,136 surveys were completed. Of that total, 1,692 (79%) were completed at VITA sites, and 444 (21%) were collected through door-to-door canvassing.

The survey was conducted between January and April 2005 using a written questionnaire developed by The Access Project and local partner organizations. To minimize selection bias, every person who registered for tax assistance at a VITA site during a time the survey was being conducted was asked to participate and was assured both of confidentiality and that declining participation would not affect the receipt of services. The questionnaire was either administered by a surveyor who had been trained on this specific instrument or was self-administered by the respondent, with trained surveyors nearby to provide needed clarifications. Information supplied for the survey was self-reported and not verified with other sources. The questionnaires were available in English and Spanish.

The VITA sites were chosen as the main venues for this survey because they provided a reliable pool of low- and moderate-income working people who are especially vulnerable to the hazards of medical debt. Many people who seek tax assistance at VITA sites do so in order to claim the Earned Income Tax Credit (EITC) and receive a refund without incurring the expense of a commercial tax preparer.[44] The credit is available to people with income from wages up to a certain level—about $35,000 in tax year 2004 for families with more than one child, and somewhat less for families with one or no children.[45] The maximum credit in 2004 was $4,300 for workers with two or more children, $2,604 for workers with one child, and $390 for workers not raising a child; the average EITC in 2003 was $2,100.[46] If the credit exceeds a family's tax liability, that excess is refunded to the family as a direct payment.[47]

42. *See infra* app. A.

43. *See infra* Section III.D.

44. Robert Greenstein, *The Earned Income Tax Credit: Boosting Employment, Aiding the Working Poor* (Ctr. on Budget & Pol'y Priorities, Washington, D.C.), Aug. 17, 2005, at 6, *available at* http://www.cbpp.org/7-19-05eic.pdf.

45. CTR. ON BUDGET AND POL'Y PRIORITIES, FACTS ABOUT THE EARNED INCOME CREDIT 3 (2005), *available at* http://www.cbpp.org/eic2005/eic05-factbook.pdf [hereinafter EARNED INCOME CREDIT FACTS].

46. *Id.*; Greenstein, *supra* note 44, at 2.

47. EARNED INCOME CREDIT FACTS, *supra* note 45, at 5.

III. SURVEY FINDINGS[48]

A. Demographic Characteristics of Survey Respondents

The VITA site sample was racially and ethnically diverse. Of the 1,692 survey respondents, about a third (34%) of the survey respondents were African American, 29% were white, 3% were American Indian, and 2% were Asian or Asian American. Fourteen percent identified themselves as Hispanic (of any race). Just under one-fifth (18%) of respondents did not identify a race or ethnicity.

Additionally, 69% of the sample were not married; 31% were married. Households had an average of about 1.6 children, 28% had no children, 28% had one, and 45% had two or more. A large majority (91%) of respondents were under age 65.

Because many people use the VITA sites to claim the EITC, we assumed that survey respondents would fall largely within the income range eligible for the credit.

This proved to be the case: 38% of the sample had incomes below $15,000, 34% between $15,000 and $25,000, and 20% between $25,000 and $35,000. Only 8% of our sample had incomes over $35,000, beyond the range of eligibility for the tax credit.

To determine whether our sample was representative of a larger national group of low-income families, we compared the demographics of our sample with national data on tax filers who claim the EITC. In general, the incomes of our sample were slightly higher, there was a somewhat higher proportion of childless families—though a vast majority, 73%, had children—and respondents to our survey were more likely to be married than the typical EITC recipient. In short, our sample is slightly better off economically than the EITC population overall, suggesting the possibility that the sample's experience with medical debt would understate the experience of a typical EITC family. This data is collected in Table 1:

48. The bulk of findings reported here are from the VITA sub-sample of 1,692 respondents. The "Site-Specific Findings" Section reports on the full sample of 2,136. *See infra* Section III.D.

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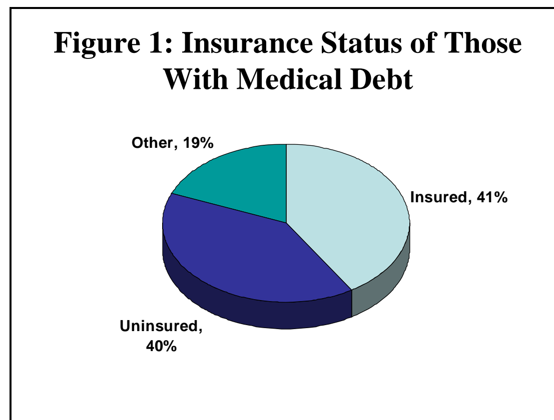
TABLE 1: DEMOGRAPHICS OF SURVEY RESPONDENTS		
	% of VITA site sample	% of EITC tax filers nationally[49]
Race/Ethnicity		
African American	34	
White	29	
Hispanic (any race)	14	
American Indian	3	
Asian/Asian American	2	
2 or more races	1	
Race unknown	18	
Age		
Under 65	91	
65 and older	9	
Marital Status		
Married	31	22
Unmarried	69	78
Number of Children		
Average	1.6	
Zero	28	19
One	28	39
Two or more	45	42
Income		
Less than $15,000	38	55
$15,000 to less than $25,000	34	30
$25,000 to less than $35,000	20	
$35,000 and above	8	

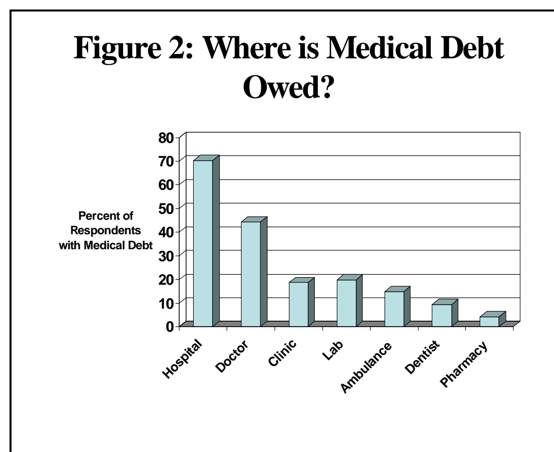
49. For national statistics on income and number of children, see MICHAEL PARISI, INTERNAL REVENUE SERVICE STATISTICS OF INCOME DIVISION, INTRODUCTION AND CHANGES IN LAW 12 (I.R.S. Publ'n No. 1304, 2002), *available at* http://www.irs.gov/pub/irs-soi/02insec1.pdf. For statistics on marital status, see Adam Carasso & C. Eugene Steuerle, *Projected Distribution of EITC Claims in 2003*, TAX NOTES, July 19, 2004, at 301, *available at* http://www.urban.org/UploadedPDF/1000669_TaxFacts_071904.pdf.

B. Medical Debt

1. Prevalence and Sources of Debt

Medical debt was prevalent among the participants in our survey. Of the 1,692 in the sample, nearly half (46%) of survey respondents reported having medical debt. As shown in Figure 1, slightly more respondents with debt said they had health insurance than not at the time they received the care for which they owe money.[50] Additionally, there was some commonality among those surveyed as to the source of their medical debt. Most of the people with debt (70%) owed hospitals and nearly half (44%) owed doctors (Figure 2). Smaller but significant numbers owed many other types of medical providers. Even aside from hospital bills, 74% of survey respondents with medical debt owed other providers, and 27% owed more than two types of providers.





50. "Other" includes the response "Don't Know" and instances where the family included some members that were insured and others that were uninsured among members with medical debt.

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2. Characteristics of Debtors

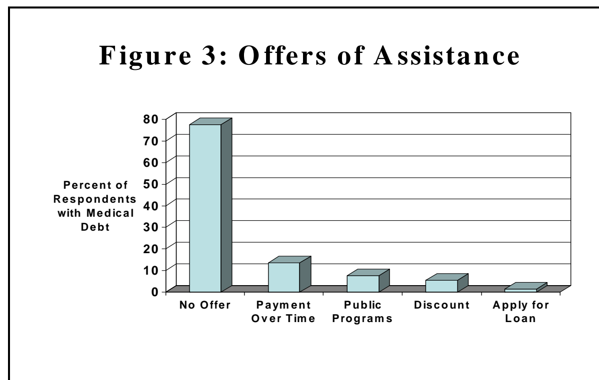
Though there were variations in medical debt by race and ethnicity, the more important finding is that all racial and ethnic categories were substantially affected. Among the respondents who identified their race or ethnicity, Asian Americans (53%), African Americans (52%), and Hispanics of any race (50%) were most likely to report having medical debt. The lowest incidence of medical debt was among American Indians, but at 40% the proportion was still high.[51] People at various income levels—at least in the range covered by the survey—were also similarly affected. Between 43% and 49% of people in all income classes—from below $15,000 to over $35,000—said they had medical debt.

Non-elderly people were much more likely to face the burdens of medical debt than people age 65 and above (47% versus 29%). Possible explanations for this are that programs for seniors such as Medicare are largely effective in protecting them from financial difficulties, and that seniors are relatively insulated from cutbacks in private insurance or state Medicaid programs that provide the bulk of coverage to younger people.[52]

3. Financial Assistance for Debtors

Despite the high number of respondents with medical debt, financial relief was not typically forthcoming or available. Three-quarters of respondents with medical debt (78%) received no offers of financial assistance from their medical providers. Of those who did, the most common forms of assistance were a payment plan over time or information about public programs to which they might apply. In fact, only 6% said they had been offered a discount on their bill (Figure 3).[53]

Figure 3: Offers of Assistance



51. Forty-four survey respondents identified themselves as American Indian.

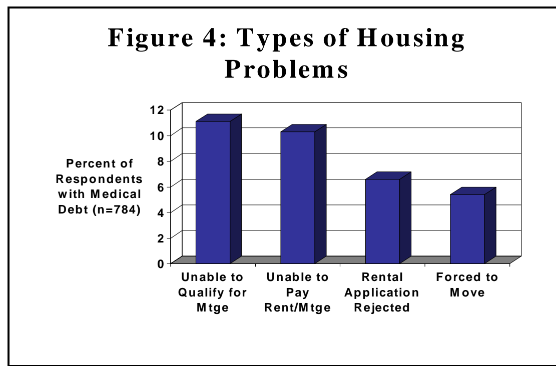
52. *See generally* Mark V. Pauly, *Conflict and Compromise Over Tradeoffs in Universal Health Insurance Plans*, 32 J.L. MED. & ETHICS 465 (2004).

53. The survey did not ask whether the original bill may have reflected a sliding fee scale based on a person's income. To the extent that was the case, this statistic may under-report the percentage of people who received a discount on their bill.

C. Housing Problems and Financial Effects of Medical Debt

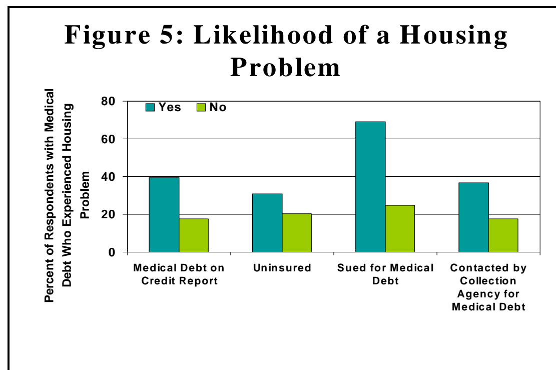
1. Existence of Housing Problems

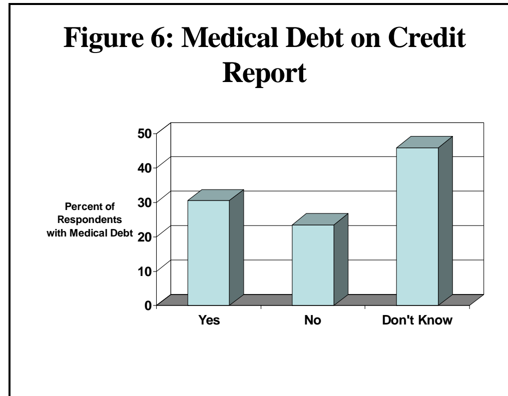
As a side effect of medical debt, a significant number of respondents were faced with problems obtaining and retaining housing. In fact, more than one quarter (27%) of survey respondents with medical debt said they had housing problems resulting from the debt. The most common problems were inability to qualify for a mortgage (11% of all respondents with medical debt), inability to pay rent or mortgage (10%), being turned down from renting a home (7%), and being forced to move to less expensive housing (5%) (Figure 4). A small number of respondents said that they were evicted (2%) and/or were now homeless (2%) because of medical debt.



2. Significance of Health Insurance

The availability of health insurance did not eliminate housing problems. Respondents without health insurance were more likely to have larger debts; about 38% of respondents with health insurance at the time they acquired medical debt had debts smaller than $500. Among those with debt, those who were not insured were more likely to say that the debt led to a housing problem. However, a significant number (about one in five) of those who had been insured experienced housing problems as well (Figure 5).





3. Relationship Between Credit Reporting and Housing Problems

Many respondents with medical debt (46%) did not know whether the debt was included in their credit report. Of those who did know, nearly three in five said that it was included (Figure 6). These people were twice as likely to report having housing problems than those who reported that their medical debt was *not* on their credit report (39% versus 18%; Figure 5).

The survey suggests that debt does not have to be particularly large nor particularly old to affect one's credit standing. While larger debts were more likely to appear on a credit report (77% of debts greater than $1,000), smaller debts can harm credit as well. About one in six respondents (16%) who said medical debt was on their credit report had debts under $500 and over one-third (35%) had debts under $1,000. Similarly, while medical debt older than one year was highly likely (78%) to be on a credit report, a quarter of debts (23%) less than a year old were reported as well.

4. Relationship Between Characteristics of Debt and Income with Housing Problems

The amount of outstanding medical bills was distributed fairly evenly from relatively low (less than $500) to very high ($5,000 or more), with bills in the $1,000 to $5,000 range most common. About half (52%) of the people with outstanding bills of $5,000 or more reported having a housing problem resulting from medical debt. While people with larger bills were more likely to face a problem, those with much smaller bills were not immune: 12% of respondents with medical debts of less than $500 reported housing problems as well (Figure 7).

While longer-term medical debt was more strongly associated with housing problems than shorter-term debt, housing problems persisted throughout the pool of respondents. Over half (55%) of respondents with debt more than five years old reported housing problems. Still, 16% of those with debt less than one year old reported problems as well (Figure 7). Income level

also appeared to have little association with resulting housing problems. Similarly, all racial and ethnic groups reported a substantial level of housing problems; there were no statistically significant differences[54] among them (Figure 8).

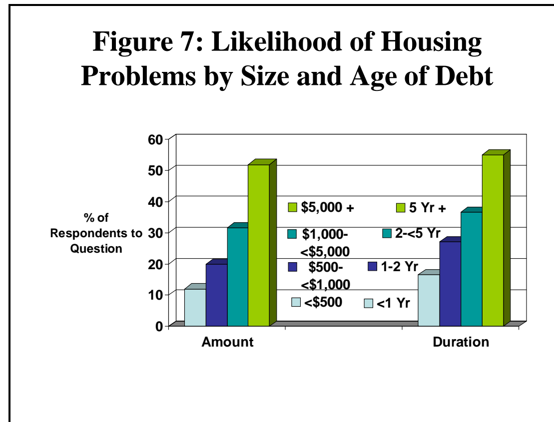


Figure 7: Likelihood of Housing Problems by Size and Age of Debt

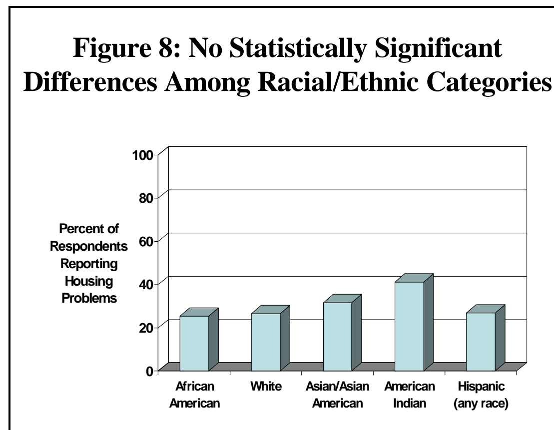


Figure 8: No Statistically Significant Differences Among Racial/Ethnic Categories

5. Relationship Between Collection Actions and Housing Problems

As might be expected, the survey also established a connection between housing problems and collection actions. Half of respondents with medical debt (50%) had been contacted by collection agencies. Five percent had been sued for the debt. People who had been contacted by collection agencies or who had been sued were more likely to report that the debt resulted in housing problems (Figure 8) than those who had not. There was also an association between housing problems and actions resulting from legal judgments such as

54. $p < 0.1$

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home liens, other property liens, and wage garnishment, but the number of respondents who experienced these actions was small in the survey sample.

Bankruptcy was a minor effect of medical debt in this survey, relative to other consequences; 7% said they had filed personal bankruptcy since owing money for medical bills. This is not out of line with the rate of personal bankruptcy nationally, however; about 1.5% of U.S. households declare bankruptcy each year.[55]

D. Site-Specific Findings

Medical debt and resulting housing problems were frequent in every site that participated in the survey.[56] Appendix B incorporates the data collected through door-to-door surveying, in addition to the surveys from the tax assistance sites. Some of the key findings follow:

- Atlanta had the highest prevalence of medical debt; Tulsa and Phoenix the lowest (Figure 9).
- Medical debt was fairly evenly distributed across income categories in most sites. The exception was Bridgeport, where medical debt was more likely for lower income respondents.
- Asian Americans reported a disproportionately high level of medical debt in Des Moines and Tulsa. Respondents of Hispanic descent had a disproportionately high level of medical debt in Palm Beach and Tulsa, but reported medical debt at a low rate in St. Louis. Respondents who identified themselves as being of more than one race had higher levels of medical debt in Tulsa.
- With the exception of Atlanta, at least one out of six respondents with medical debt in each site reported that the debt resulted in a housing problem. Bridgeport respondents most frequently (36%) said the debt resulted in a housing problem. At other sites the proportion ranged from 16% to 31% (Figure 9).
- Respondents in most sites reported they were insured at the time the debt was incurred about half the time (Phoenix, Palm Beach, Providence, and Tulsa) or more (Atlanta, Bridgeport, and St. Louis). Four of ten respondents in Des Moines said they were insured.

55. This calculation is based on data from the U.S. Courts, Bankruptcy Statistics, *available at* http://www.uscourts.gov/bnkrpctystats/bankruptcystats.htm (last visited Jan. 22, 2007), and the U.S. Bureau of the Census, Households, *available at* http://www.census.gov/compendia/statab/tables/06s0053.xls (last visited Jan. 22, 2007).

56. A table containing site-specific findings appears in Appendix B.

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- Respondents commonly reported that medical debt appeared on their credit reports. At least four in ten respondents (Tulsa) and as many as eight in ten (Atlanta) said the debt was on their credit report.

- Respondents in four sites (Atlanta, Palm Beach, Providence, and St. Louis) were more likely than not to say they were contacted by a collection agency about their medical debts, and were about equally likely as not in two sites (Bridgeport and Tulsa). A minority of respondents in Des Moines (30%) and Phoenix (44%) said they were contacted.

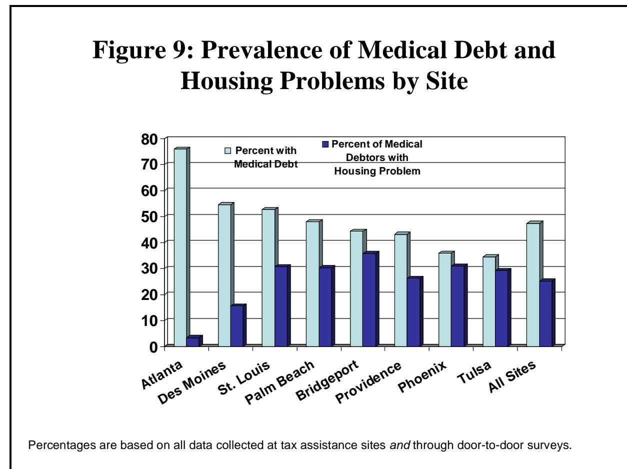

Figure 9: Prevalence of Medical Debt and Housing Problems by Site

Percentages are based on all data collected at tax assistance sites *and* through door-to-door surveys.

IV. DISCUSSION

This large-scale survey, conducted in eight locations across the country, verifies a central finding of a number of recent studies: medical debt is a common phenomenon. In this case, it was present among nearly half of the survey respondents, most of whom were low- and moderate-income, working age adults. Many of these adults were present where the surveys were conducted, VITA centers, because they had employment income and were eligible for the federal EITC. A majority had health insurance at the time they acquired the debt. Most had children living with them. In short, working families of modest means are at high risk for medical debt and its attendant consequences. Past research indicates that these consequences include restricted access to medical care for all family members, depletion of savings, and harassment by collection agencies, all of which constitute barriers to economic advancement and healthier and more secure lives.[57]

57. *See* ANDRULIS ET AL., *supra* note 3 and accompanying text.

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A. Housing and Credit Problems

In addition to confirming the findings of past research, this survey introduces new information about consequences of medical debt. A quarter of the respondents with debt said they had experienced some type of housing problems as a result of it. These problems include being unable to qualify for a mortgage, to make mortgage or rent payments, or qualify to rent a home, and the need to move to a less costly home. These findings establish medical debt as a barrier to still other important elements of economic advancement, namely asset development and housing security.[58]

An analysis of the demographic and financial characteristics of the survey respondents whose medical debt led to housing problems suggests that the risk of such an outcome is widespread. A significant portion of respondents with medical debt—regardless of their age, income, marital status and ethnicity—had housing problems as a result. Within the scope of this survey, no group appears to have been invulnerable to the effects on housing situations of medical debt.

That medical debt commonly leads to housing problems in this study should not be a surprise, given the general prevalence of medical debt among low and moderate income families, who tend not to have much money to spare for unplanned expenses. What is sobering is that even relatively small levels of medical debt—$500 or less—can create housing and other economic hardships for families. These disadvantages seem out of proportion with the modest debt that brings them on, and $500 may constitute a significant percentage of family income. An additional finding is that housing problems become more likely as medical debt lingers.

Some of the housing problems reported in this study simply reflect the fact that medical debt, because it lays a claim to families' available resources, diminishes the amount available to use for other purposes, such as rent payments or home maintenance. Other problems, however, are indicative of deeper issues. The inability to qualify for a mortgage or even to rent an apartment, for example, is a signal of damaged credit, which has broad ramifications. Medical debt affected the credit of at least a third of the survey respondents with debt, and these people were more than twice as likely as those whose medical debt did not mar their credit to report a housing problem. This is especially significant because nearly half of those surveyed said they

58. Home ownership has been shown to be a major instrument of wealth accumulation for middle class families, as well as having significant inter-generational effects for low-income families, such as the increased likelihood of a homeowner's children owning homes themselves and having higher incomes and more advanced education. *See, e.g*, Thomas P. Boehm & Alan M. Schlottmann, *Housing and Wealth Accumulation: Intergenerational Impacts* (Joint Ctr. for Hous. Studies of Harvard Univ., 2001), *available at* http://www.jchs.harvard.edu/publications/homeownership/liho01-15.pdf.

did not know whether medical debt was on their credit report. Our findings suggest that those who are not yet aware of their credit status are more likely than not to find their credit hurt—an unwelcome surprise when trying to buy a home or to gain access to other credit.

B. The Importance of Credit Reporting

Barriers to obtaining housing are but one way that damaged credit affects people's lives. It also limits access to affordable credit for other purposes, such as purchasing a car, which may in turn limit employment possibilities. Employers may themselves consult credit reports in making hiring decisions.[59] Insurers may consult credit reports in underwriting automobile and home coverage.[60] In some cases, people with low credit scores have been required to pay higher utility deposits. And the effects of damaged credit linger: a delinquent account, regardless of size, can remain on a credit report for seven years.[61] This risk is often multiplied by the fact that a single medical episode can result in many bills—from a hospital, doctor, ambulance, laboratory, and so on—and, therefore, many scars on a credit report.

Unlike many other types of debt, medical debt usually can only harm a credit rating, not help it.[62] When medical providers and their collection agents report debt to credit bureaus, they typically do so only when payments have not been made. This negative-only treatment of medical debt is all the more inequitable because it is one of the few types of debt that are involuntarily acquired. Thus, this "accidental debt," even if relatively small, essentially acts as a "sickness tax"—on top of the bills themselves and possible lost employment income—by damaging credit. And this "sickness tax" is long-term, perhaps permanent.

C. Inadequacy of Insurance "Protection"

One other finding deserves specific attention. Having health insurance did not provide adequate protection from housing problems in many cases of medical debt, although those who did not have health insurance at the time their medical debt was incurred were more likely to experience housing problems. And, although the debts of those who had health insurance tended to be smaller, even small amounts could damage credit status.

59. Fair Credit Reporting Act, 15 U.S.C. § 1681b(a)(3)(B) (2000); FED. TRADE COMM'N, NEGATIVE CREDIT CAN SQUEEZE A JOB SEARCH (2006), *available at* http://www.ftc.gov/bcp/edu/pubs/consumer/alerts/alt053.htm.

60. § 1681b(a)(3)(C)

61. § 1681c.

62. *See generally* JON HANSON, GOOD DEBT, BAD DEBT: KNOWING THE DIFFERENCE CAN SAVE YOUR FINANCIAL LIFE (2005). Good debt helps to gain assets that produce income, for example student loans or real estate loans. Bad debt does not produce any cash flow. It is money borrowed for something that loses value, for example car loans or credit card debt.

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That health insurance seems not to have served its fundamental purpose for many survey respondents—protecting families against great financial exposure—warrants further attention. The current trend of passing more of the financial burden of health care to individuals through higher deductibles and co-payments in the name of "individual responsibility," combined with rapidly increasing health care costs, particularly for the chronically ill, raises crucial questions about the deteriorating adequacy of insurance that should be addressed in the policy arena.

V. POLICY RECOMMENDATIONS

So what can be done? The effects uncovered in this survey are likely only to worsen as health care costs increase, the numbers of uninsured rise, and those fortunate enough to maintain health coverage are required to absorb more of the cost. Medical debt is affecting access to housing at the same time that housing is becoming increasingly unaffordable for families of modest means,[63] and the medically-related credit problems that cause these housing problems hinder families' economic advancement in many other ways.

Legislators and other policy makers, as well as members of the sectors that contribute to this problem—medical providers, health insurers, employers and lenders—should consider a number of areas in which they might respond in an effort to reduce the "sickness tax" that medical debt imposes. If the market and private actions are unable to relieve the problem, legislation or regulation requiring some of these changes would be an appropriate next step.

A. Medical Providers

Medical providers can contribute to solving the problem by reducing the amount of medical debt they create and by changing practices that result in additional financial difficulties for patients. For example, publicity in the last few years about hospitals' practices of billing uninsured patients their highest fees and pursuing them using overly-aggressive collection practices have led to greater attention to charity care and collections policies.[64] Some hospitals have revamped their practices by offering greater discounts to low-income uninsured patients and restricting practices like wage garnishments and property liens.[65] Still, many hospitals have not addressed their policies at all,

63. Media Release, Ctr. for Hous. Pol'y, U.S. Housing Prices Rise 20 Percent Nationwide, While Wages for Key Community Workers Remain Relatively Flat (Aug. 9, 2005), *available at* http://www.nhc.org/index/News-PR-Center05P2P-080905.

64. *See, e.g.*, ROLLINS, *supra* note 33; Lagnado, *supra* note 33.

65. The Healthcare Financial Management Association's "Patient-Friendly Billing Project" (www.patientfriendlybilling.org) has provided valuable leadership to hospitals on these issues. *See* PATIENT-FRIENDLY BILLING PROJECT, HOSPITALS SHARE INSIGHTS TO IMPROVE FINANCIAL POLICIES FOR UNINSURED AND UNDERINSURED PATIENTS (2005), *available at* http://www.eclipsys.com/Solutions/pdfs/2005_pfb_report.pdf.

and some that have are not making their policies well known to the general public.[66] Hospitals can also limit the creation of medical debt—and enhance their revenues—by adequately screening patients for eligibility in public insurance programs, such as Medicaid, and by agreeing to reasonable payment plans that low-income patients can fulfill.

The significant numbers of respondents in this study who reported debt to doctors and other non-hospital providers also remind us that these other providers have not been held to account on this issue to the same extent as hospitals. Further scrutiny and standards regarding providers' relationships with collection agents, lenders, and credit bureaus would bring focus to additional policy solutions.

B. Insurers and Employers

That people with health insurance are affected by medical debt and its consequences almost to the same degree as those without calls into question the adequacy of some insurance in protecting policy holders from financial catastrophe. New developments in health insurance products—health savings accounts, high deductible plans, limited benefit policies, "consumer-driven health care"—put families with little excess income at risk and challenge the very notion of health insurance. In fact, many of these plans have deductibles of $1,000 or more,[67] well above the level of debt that harmed the respondents in our study. Employers who want to continue offering coverage to their employees in the face of ever-rising premiums often have little choice but to pass along more of the cost of the coverage, increasing the risk of medical debt for their employees. Little has been demanded of insurers, however, many of which have enjoyed robust profits in the last few years.[68] Standards for

66. BILL LOTTERO & CAROL PRYOR, ACCESS PROJECT, VOLUNTARY COMMITMENTS: HAVE HOSPITALS THAT SIGNED A CONFIRMATION OF COMMITMENT TO THE AMERICAN HOSPITAL ASSOCIATION'S BILLING AND COLLECTIONS GUIDELINES REALLY CHANGED THEIR WAYS? 3, 14 (2005), *available at* http://www.accessproject.org/adobe/voluntary_commitments.pdf.

67. *See, e.g.*, Regence BlueShield of Idaho, *RegenceEssential $5,500 Deductible for Individuals Benefit Summary*, *available at* http://www.id.regence.com/docs/summaries/individual/regenceEssential5500.pdf; Assurant Health, *RightStart Plan*, http://www.assurant health.com/corp/ah/HealthPlans/RightStartPlan.htm (last visited Jan. 8, 2007). *See generally* KAREN DAVIS ET AL., COMMONWEALTH FUND, HOW HIGH IS TOO HIGH? IMPLICATIONS OF HIGH DEDUCTIBLE HEALTH PLANS (2003), *available at* http://www.cmwf.org/usr_doc/816_Davis_how_high_is_too_high_impl_HDHPs.pdf.

68. *See, e.g.*, Humana, Inc., Current Report (Form 8-K), at ex. 99 (Aug. 1, 2005) (indicating that Humana also reported a 30% increase for the first half of 2005); UnitedHealth Group, Inc., Current Report (Form 8-K), at ex. 99 (July 14, 2005) (indicating that UnitedHealth Group's corporate filings indicate a 30% increase in profits from the second quarter of 2004 to the second quarter of 2005); Greg Andrews, *Here's a Blues Performance That Won't Get You Down*, INDIANAPOLIS BUS. J., Sept. 5, 2005, at 4 (reporting an analyst's estimate that WellPoint will earn profits of $2.5 billion this year, on revenues of $45 billion).

adequate coverage, including cost-sharing obligations that are proportionate to family incomes, might be explored, as well as programs to provide benefits to the communities in which insurers operate. This year, for example, the four Pennsylvania Blue Cross plans agreed to create a "Community Health Reinvestment Fund," which could blaze a trail for the recognition of insurers' community obligations elsewhere.[69]

Further research is also needed to understand the relative influences of various shortcomings in health insurance—excessively high deductibles, breaks in coverage, uncovered services—on medical debt and its resulting problems. Knowledge of this sort will help policy makers determine how to set standards for adequate coverage, so that the purpose of health insurance as financial protection might be restored and maintained.

C. Lenders and Affiliated Organizations

A consensus appears to exist among those who make and advise others about lending decisions that medical debt should be considered differently from other types of personal debt. Fair Isaac and Company, a major credit scoring organization, considers medical debt to be "atypical and non-predictive" of overall credit worthiness, for example.[70] While lenders might reasonably be asked to develop explicit policies for segregating medical debts in considering an applicant's eligibility for credit, such an approach presumes that medical debt is readily identifiable as such on a credit report. If a delinquent account is listed by the name of a collection agency rather than a medical provider, or if a bill has been paid with a credit card or at the expense of another bill that therefore replaces the delinquent medical bill, medical debt might not be identifiable as such. Lenders, who might like to discount or disregard medical debt in their decision making, thus often do not have sufficient information to implement such policies.

Given the atypical nature of medical debt and the commonly expressed policy to treat it differently, one might question the need for health care providers to report these debts to credit bureaus at all. Lenders, creditors, credit bureaus, and regulators should consider ways to prevent medical debt from ever tarnishing a credit record, including rules to prohibit medical providers and their agents from reporting medical debt to credit agencies.

CONCLUSION

If there is a more vulnerable circumstance for a person to be in than being ill, it is probably to be ill and in debt. This report has shown that such

69. Bill Toland, *Blues Insurers Helping Fund Programs that Provide Health Coverage to Poor*, PITT. POST-GAZETTE, Feb. 8, 2005, at A1.

70. Robert W. Seifert, *The Demand Side of Financial Exploitation: The Case of Medical Debt*, 15 HOUSING POL'Y DEBATE 785, 793 (2004).

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vulnerability is not rare among our survey respondents. To compound this, medical debt often results in housing and credit problems, which may in turn bring about further crippling financial difficulties.

Repairing the health care system—controlling costs, improving quality, ensuring access, and eliminating disparities—is a challenge of national scope that has, to date, been maddeningly elusive. Smaller victories are achievable, however. One place to look is eliminating the financial penalty imposed on people for getting sick. Remedies—on the part of policy makers, medical providers, insurers, and lenders—are at hand. All that is needed is action.

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APPENDIX A

TABLES SHOWING AGGREGATE DATA

The following tables present data collected at the Volunteer Income Tax Assistance (VITA) sites only (n=1,692). See Section II (Methods) of this report for further explanation.

Table A1. Respondents with Medical Debt
n = 1,692*

	Number
All Respondents	1,692
Number with Medical Debt	784
Percentage with Medical Debt	46.3
Of Respondents with Medical Debt (%):	
Health Insurance at time debt acquired	
Yes	41.0
No	40.1
Other[1]	18.9
Type of provider owed	
Hospital	70.3
Doctor	44.3
Clinic	18.7
Lab	19.8
Ambulance	14.9
Dentist	9.4
Pharmacy	4.2
Provider offered financial assistance	
No offer	77.7
Payment plan over time	13.6
Informed of public programs	7.5
Discount on bill	5.5
Help applying for loan	1.3
Amount of debt	
<$500	28.7
$500-<$1,000	21.9
$1,000-<$5,000	33.8
$5,000 +	15.6
How long had debt	
< 1 year	36.4
1 to 2 years	36.4
> 2 but < 5 years	18.7
5 years or more	8.6

[1]"Other" includes the response "Don't Know" and instances where the family included some members that were insured and others that were uninsured among members with medical debt.

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Table A2. Housing Problems and Other Financial Effects of Medical Debt

Respondents with Medical Debt	784
Number of Medical Debtors with Housing Problems	213
Percentage of Medical Debtors with Housing Problems	27.2
Type of Housing Problem	
Unable to qualify for mortgage	11.1
Unable to pay rent or mortgage	10.3
Rental application rejected	6.6
Forced to move to less expensive housing	5.4
Unable to do home repair/maintenance	4.1
Unable to pay property taxes	2.6
Unable to maintain housing, now homeless	2.2
Refinanced/took second mortgage to pay bills	1.9
Evicted	1.7
Medical debt on credit report	
Yes	30.6
No	23.5
Don't know	45.9
Contacted by collection agency	49.6
Sued in small claims court	5.4
Filed personal bankruptcy	6.8

Table A3. Association Between Housing Problems and Selected Characteristics

	Percentage with housing problems
Health insurance at time of debt	
Yes	30.9
No	20.3
Medical debt on credit report	
Yes	39.4
No	17.5
Amount of debt	
<$500	12.0
$500-<$1,000	19.9
$1,000-<$5,000	31.6
$5,000 +	51.9
How long had debt	
< 1 year	16.5
1 to 2 years	27.1
> 2 but < 5 years	36.6
5 years or more	55.0
Income	
Less than $15,000	29.2
$15,000 to less than $25,000	27.2
$25,000 to less than $35,000	30.5
$35,000 and above	17.3
Race/Ethnicity	
African American	25.5
White	26.5
American Indian	41.2
Asian/Asian American	31.6
Hispanic (any race)	27.0
2 or more races/race unknown	30.0
Contacted by collection agency	
Yes	36.8
No	17.7
Sued in small claims court	
Yes	69.0
No	24.8

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APPENDIX B

SITE-SPECIFIC DATA

This table presents all of the survey data collected for the survey from the VITA sites (n1=1,692) and through door-to-door canvassing (n2=444; Total N= 2,136). See Section II (Methods) of this report for further explanation.

	ATLANTA	BRIDGEPORT	DES MOINES	PHOENIX	PALM BEACH	PROVIDENCE	ST. LOUIS	TULSA
Number of Surveys	154	151	291	415	397	88	383	257
Percentage with Medical Debt	76%	44%	55%	36%	48%	43%	53%	35%
by income:								
<$15,000	65%	56%	56%	31%	47%	50%	56%	37%
$15,000-$25,000	82%	45%	52%	41%	62%	55%	51%	27%
$25,001-$35,000	80%	41%	55%	37%	48%	*	48%	36%
>$35,000	70%	33%	58%	32%	50%	*	56%	31%
by race/ethnicity:								
African American	74%	48%	52%	35%	56%	50%	56%	32%
White	*	36%	58%	40%	46%	41%	48%	34%
Asian/Asian American	*	*	67%	*	*	*	*	45%
American Indian	*	*	*	*	*	*	*	28%
Hispanic (any race)	82%	39%	48%	39%	60%	36%	38%	45%
Multiple Races/Other	*	47%	*	34%	27%	45%	57%	47%
Percentage with Medical Debt who reported:								
Housing Problem due to Medical Bill	3%	36%	16%	31%	30%	26%	31%	29%
Medical Debt on Credit Report	82%	59%	49%	65%	71%	50%	57%	41%
Insured at Time Debt Acquired	64%	59%	39%	49%	47%	52%	64%	49%
Contracted by Collection Agency	71%	49%	30%	44%	60%	71%	55%	48%
Sued for Debt	3%	13%	4%	5%	2%	13%	6%	7%
Bankruptcy	14%	6%	3%	9%	5%	3%	9%	6%

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