



Living In The Red

Medical Debt and Housing Security In Missouri

Survey Findings and Profiles of Working Families



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Introduction

Medical bills can cripple hardworking families. As the Missourians profiled in this report explain, consumers expect to and want to pay for the medical care they receive. But family budgets can be overwhelmed by the costs of medical care and the financial impact of illness and injury.

In January and February 2005 a survey of working families in the St. Louis area asked: Do you owe money for medical care?¹ Over half (53%) of the families said yes—they owed medical debt. These families then went on to respond to questions about who they owed and how unpaid medical bills affected their financial well-being and, particularly, their ability to get and keep housing. Most striking, over half (52%) of the families who were struggling to pay off medical bills said they had health insurance when they sought treatment. This report presents key findings from that survey about the causes and consequences of medical debt.²

This report also tells the personal stories that bring life to the statistics. Seven Missouri residents from across the state share their personal experiences telling how medical debt affects financial and emotional stability, and access to health care. People with medical debt are our neighbors, friends and colleagues. They work hard, support their families, and live in small towns, suburbs and big cities. And, often-times, people with medical debt have insurance that fails to protect them from the overwhelming costs of medical care.

Key Findings

Medical debt problems are widespread. More than half (53%) of St. Louis families surveyed said they had medical debt from unpaid medical bills from hospitals, doctors and other providers.

Health insurance may not protect from medical debt. In St. Louis more than half (52%) of survey respondents who reported medical debt had health insurance at the time the medical debt was incurred.

While medical debt from hospital bills is the most frequently reported problem, families also report substantial medical debt owed to doctors, clinics, labs, and ambulances. Over two-thirds (72%) of the survey respondents who had medical debt said they owed hospitals, but about the same percentage said they owed money to other medical providers as well, including doctors, clinics, labs, ambulances, dentists, and pharmacies.

Medical debt frequently leads to housing problems. Nearly a third (31%) of St. Louis residents surveyed with medical debt said the debt resulted in housing problems.

Bad credit is a frequent result of medical debt. While a third of the people surveyed (33%) did not know whether medical debt was on their credit report, of those who did know, over half (56%) said it damaged their credit rating.

Even relatively small amounts of medical debt can have harmful effects. In the survey, 15% of St. Louisans with medical debt under \$500, and 27% with debt between \$500 and \$1,000, reported housing problems.



Name:	Lynnette and Rob Swartz
Age:	48 and deceased
Occupation:	Administrative assistant, small business owner and family farmer
Hometown:	Freeman
Medical Debt:	\$9,000

Rob Swartz died at home in February 2005 after a two-year battle with lung cancer. He left behind his wife, Lynnette, six children, six grandchildren and more than \$9,000 in medical debt. Lynnette kept the accumulating medical bills a secret from her sick husband, making sure to have the bills mailed to their post office box. She tried to spare Rob this additional stress for fear it would cause his health to decline even faster.

For thirty years before Rob fell ill, he owned and operated a small printing company that he purchased from his brother. He and Lynnette also worked their thirty-acre family farm in Freeman, Missouri. Freeman is a rural community of around 500 people outside of Kansas City. Lynnette and Rob moved to the farm in 1998, but the property has been in the family since 1974. Lynnette has also worked as an administrative assistant at JC Penney for twenty-eight years. Before Rob got sick, the couple's combined income was just under \$55,000 a year, and they had good health insurance through Lynnette's job.

Despite this, Lynnette and Rob struggled to stay afloat during the two years Rob was ill: "Rob was self-employed and we had very little savings when he became sick," Lynnette remarks. Rob's cancer treatment—which included three surgeries, five rounds of chemotherapy and home health care—came to almost half a million dollars. Even with Rob working as much as he could and Lynnette's good health coverage, the medical bills piled up.

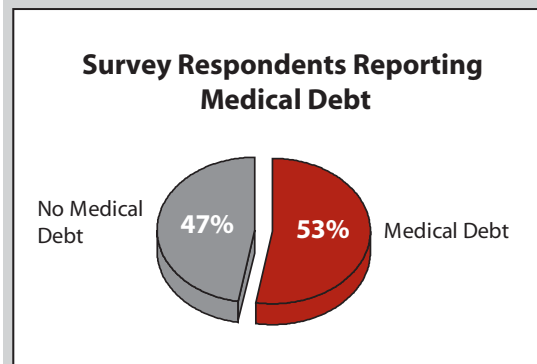
As Rob became more sick and unable to work, the couple found themselves increasingly unable to keep up with the bills. When Rob had to stop working, their income dropped by \$2,000 a month, but the medical bills kept growing. In 2003 alone, Lynnette and Rob paid \$3,000 out of their own pockets for medical expenses. In 2004, their insurance premiums increased, and they were paying up to \$300 a month for prescription drug co-payments.

Their insurance was supposed to cover 80% of Rob's medical bills, but the company balked when Rob's doctors recommended that specialists outside the insurer's preferred provider panel needed to perform two of the brain surgeries. Eventually, after lots of haggling, the insurance paid 80% of the cost of one surgery and 60% of the other, but Lynnette and Rob had to pay the rest.

Rob and Lynnette sold some of their cattle to generate a little extra money, but they still had trouble paying the bills: "We were not able to make our house payments in 2004," Lynnette explains. The couple was buying their home from Rob's parents, paying them \$500 a month. "We initially began buying our home from my in-laws with the idea that in five years we would get a bank loan and pay them off. With Rob's illness, we were not able to. We were not able to make house payments at all in 2004."

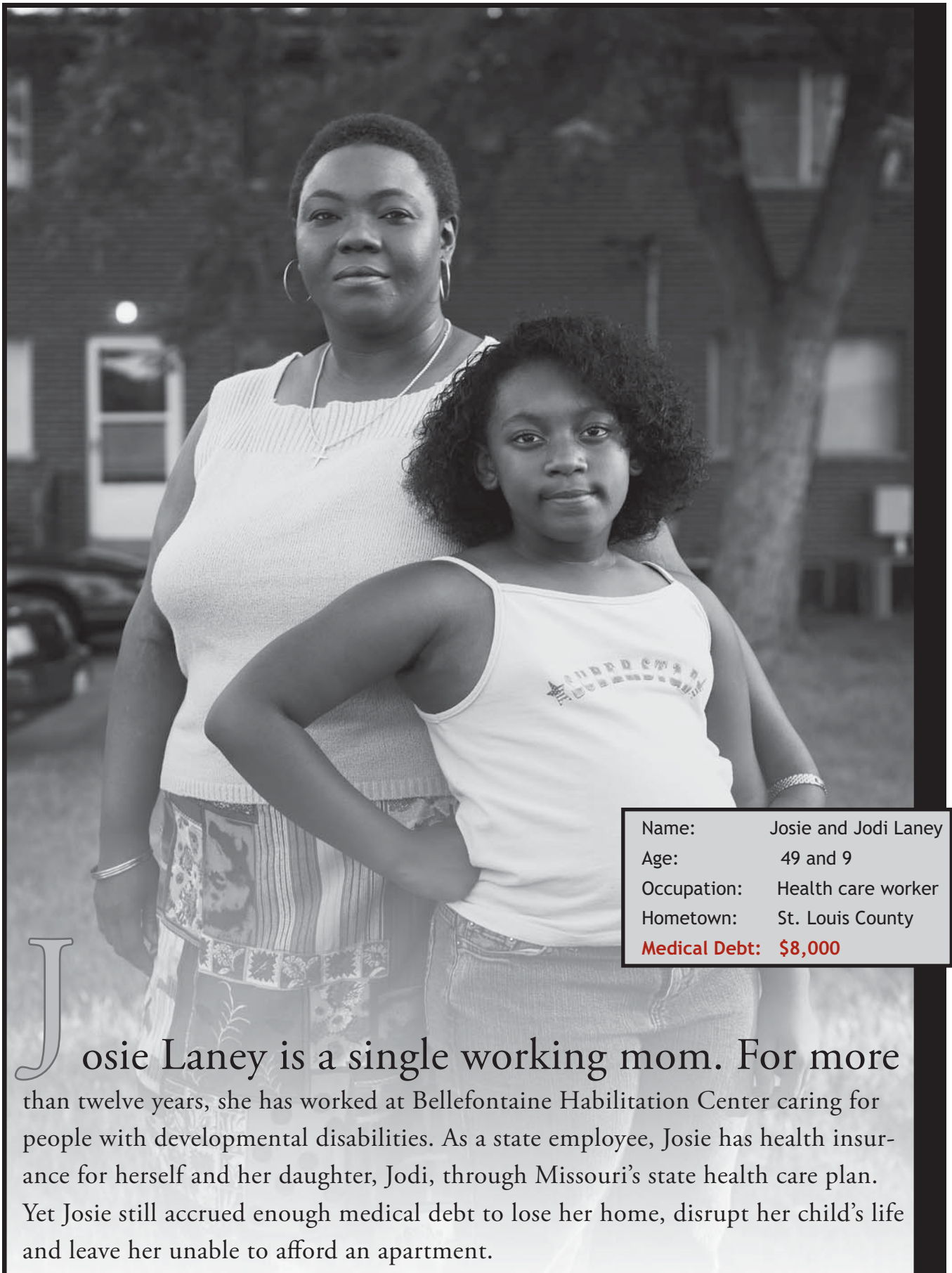
Medical Debt Problems Are Widespread

More than half (53%) of St. Louis area working families surveyed said they had medical debt from unpaid medical bills from hospitals, doctors and other providers. The debt reported was roughly equal across all incomes and all ethnic categories.



As Rob's health deteriorated, Lynnette had to rearrange her schedule at work and take vacation time to care for her husband. Her daughter helped care for Rob and other family members pitched in, but she was still unable to keep up financially: "If not for the patience of my in-laws, we would have lost our home. It would have been especially difficult for my husband. He knew that he was dying, and it was important to him to know that we would have a home."

“If not for the patience of my in-laws we would have lost our home. He knew that he was dying, and it was important to him to know that we would have a home.”



Name:	Josie and Jodi Laney
Age:	49 and 9
Occupation:	Health care worker
Hometown:	St. Louis County
Medical Debt:	\$8,000

Josie Laney is a single working mom. For more than twelve years, she has worked at Bellefontaine Habilitation Center caring for people with developmental disabilities. As a state employee, Josie has health insurance for herself and her daughter, Jodi, through Missouri’s state health care plan. Yet Josie still accrued enough medical debt to lose her home, disrupt her child’s life and leave her unable to afford an apartment.

Jodi was born in 1997 with asthma and RSV, a severe respiratory condition that requires constant care in young children. As an infant and toddler, Jodi suffered from a seemingly endless array of breathing problems, including two bouts of pneumonia. She was in and out of doctors' offices and emergency rooms. And in the midst of caring for her daughter, Josie also got sick.

In 2002, Josie had to take medical leave from her job because of stress-related nerve damage that paralyzed her left arm. While the cause is still uncertain, the injury was most likely the result of a number of factors, including working long hours at Bellefontaine. The center is chronically short-staffed and direct care workers like Josie are often required to work double shifts and extra hours to fill staffing gaps. The work is physically demanding because many of the clients are not mobile, and must be lifted, moved and carried. Long work hours lead to exhaustion, job-related injuries and high levels of work-related stress.

Josie went to doctors, specialists and physical therapists to treat the nerve damage. "I did it all just to start moving my hand again," she explains. Despite ongoing treatment and mounting medical bills, Josie never fully recovered. She still feels tingling in the fingers of her left hand and cannot rest her elbows on a table without discomfort.

Although Josie has had continuous health insurance through her state job, the cost of prescription drugs for herself and her daughter, the co-pays for frequent doctor visits and missed days of work took a toll on her financial health. Even after over a decade on the job, Josie's income as a full-time employee is only \$1,303 per month, and she still

feels financial pressure to take on overtime work to increase her paycheck. "When you have no money, co-pays of twenty-five dollars are expensive," Josie comments. "I had to borrow money so I could take my daughter to the doctor."

By 2002, Josie had amassed over \$8,000 in medical bills and fell behind on her home loan. Josie declared bankruptcy and agreed to a Chapter 13 monthly payment schedule in an attempt to pay down the medical bills and keep her home. But with recurring medical problems—both hers and Jodi's—she fell behind on the payments. In 2003, the bank got permission to foreclose on the family's home. Homeless, Josie moved in with her older sister who struggles with significant medical problems herself.

It's been almost three years since Josie lost her home because of medical debt, but she still has not been able to save enough money for a deposit and first month's rent on a new apartment. Her goal is to rent a place in

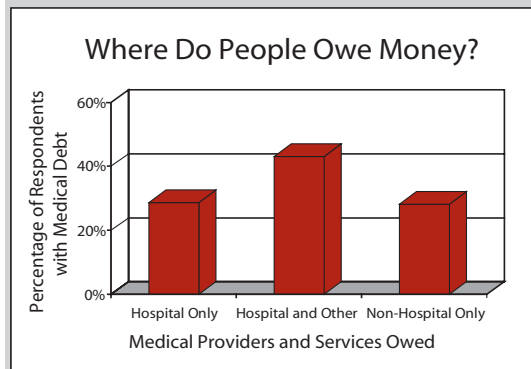
the Hazelwood school district where Jodi attends second grade and is doing well.

Instead, Josie has been paying down her medical bills and in 2005 she finally paid them off. "I worked hard for it," she explains. "When I did feel better, I made sure I worked overtime."

Josie continues to work for the state caring for clients at Bellefontaine, but she has also enrolled in a training program to become an electrician. She chose this field because it is less physically demanding and higher paying than the health care industry—she doesn't want to face homelessness or medical debt again.

While Medical Debt From Hospital Bills Is The Most Frequently Reported Problem, Families Also Report Substantial Medical Debt Owed To Doctors, Clinics, Labs, And Ambulances.

Over two-thirds (72%) of the St. Louis area residents with medical debt who responded to the survey said they owed hospitals, and about the same percentage said they owed money to other medical providers as well, including doctors, clinics, labs, ambulances, dentists, and pharmacies. Nearly half (47%) of those with medical debt owed money to two, three or more providers.





Name:	Lana Wiseman
Age:	42
Occupation:	Former taxi driver
Hometown:	Columbia
Medical Debt:	Over \$30,000

In May 2002, Lana Wiseman was 39 years old, working as a taxi driver, and without health insurance. Her employer did not offer insurance and she could not afford the premiums to buy her own policy. Even though Lana had chronic asthma problems, she routinely delayed going to the doctor in an effort to avoid medical bills. Nevertheless, she owed \$8,000 for treatments, medications, and emergency room visits. Now, after two strokes, Lana has Medicaid coverage but her medical debt is over \$30,000.

Lana's first stroke happened while she was sleeping. She noticed a loss of feeling on the left side of her body and vision problems, but delayed seeking care hoping to avoid more medical bills. When Lana finally sought medical care, she discovered that because she had not received immediate treatment for the stroke, she had suffered irreversible and permanent damage to the muscles on the left side of her body. "Now, I have very little muscle control on the left side of my face," Lana says. "When I try to smile, the left side of my face just kind of hangs there."

The permanent disability caused by the delay in seeking care means that Lana now qualifies for Medicaid which only covers adults who are parents, elderly or individuals who have permanent disabilities. Medicaid is a great help, but it does not pay all Lana's medical costs. Medicaid paid for her emergency room visits and most of the hospital care, but many of the specialty doctors she needs to see do not accept Medicaid and charge her instead. The cost of the stroke treatment "wiped out my savings in three months," she commented.

Medicaid did not pay for a \$2,500 CAT scan her doctor ordered. It is not clear whether Medicaid refused to cover the scan or the hospital improperly submitted the claim. What is clear is that when the hospital did not collect from Medicaid,

it sued Lana. With literally nothing to give the hospital, Lana explains, "I sent them a money order for one dollar once because that's all I had."

Lana has lost her job and her home. The vision and mobility problems caused by the stroke prevent her from returning to work as a taxi driver. Soon after the stroke, with medical bills needing

payment and no income, Lana got behind on the rent-to-buy payments on her mobile home in Columbia. After three years and thirty-six payments, Lana only needed to pay another \$1,100 to own the mobile home. But when she fell behind on the monthly payments, she was evicted.

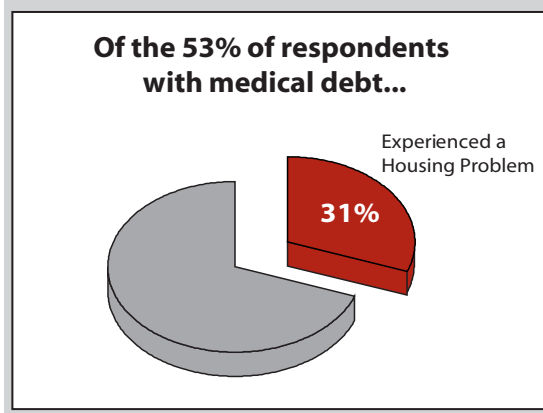
Deep in medical debt and with no income, Lana now lives with a friend. When she moved in, she promised to contribute \$100 a month towards the rent when she began receiving her disability

benefits. Lana now owes \$1,500 in rent, and the medical bills keep coming.

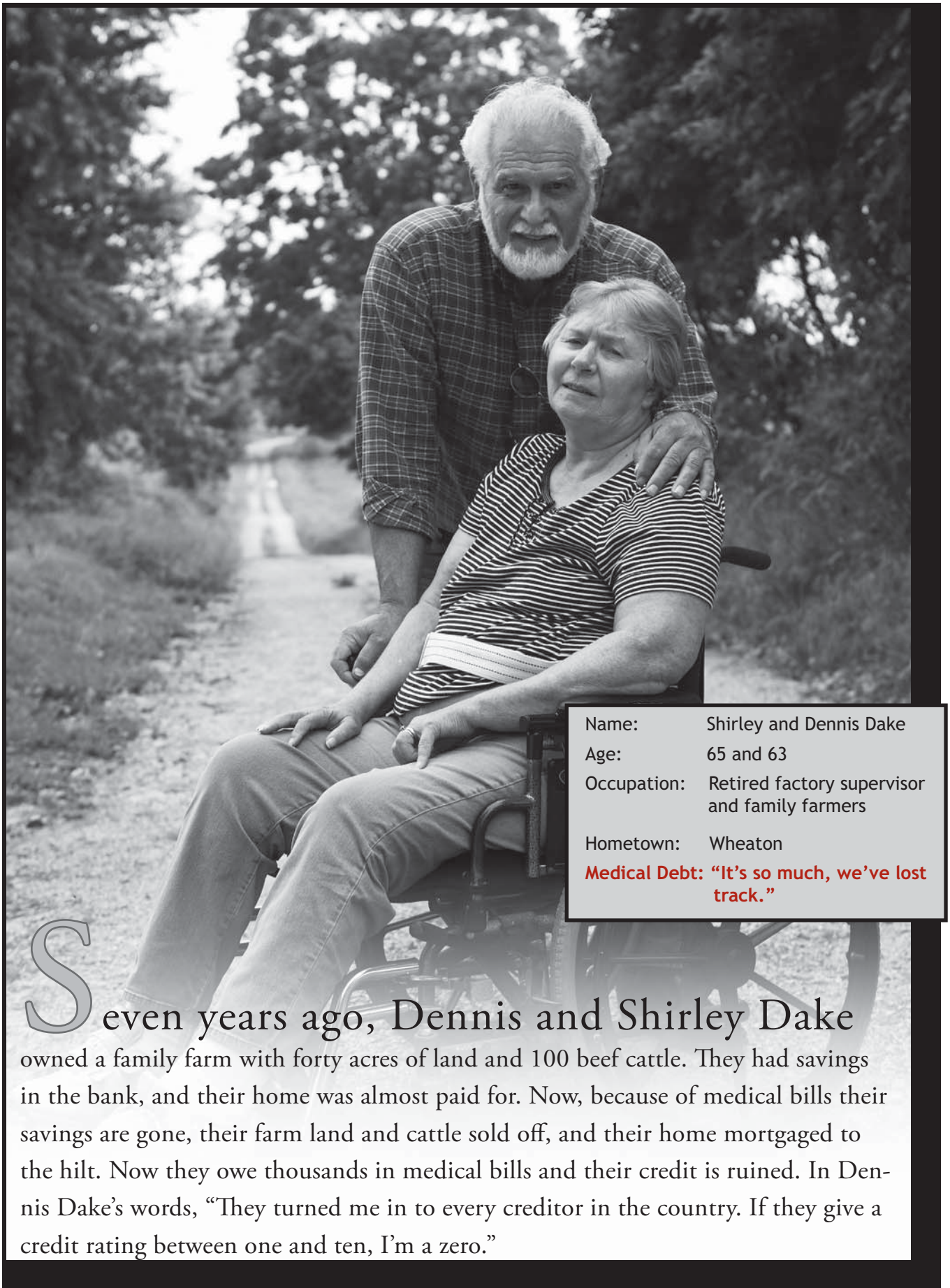
Lana currently has over \$30,000 in unpaid medical bills. Without income and unable to work, she sees no way of paying it down. She depends on her roommate for housing and support and worries that more reductions in the state Medicaid program will leave her with no chance to recover her health or her financial stability.

Medical Debt Frequently Leads To Housing Problems.

Nearly a third (31%) of St. Louis area residents in the survey who had medical debt said the debt resulted in housing problems.



“I lost my job, my home, my independence—everything that’s important to me. All that’s left is the debt.”



Name: Shirley and Dennis Dake
Age: 65 and 63
Occupation: Retired factory supervisor and family farmers
Hometown: Wheaton
Medical Debt: "It's so much, we've lost track."

Seven years ago, Dennis and Shirley Dake owned a family farm with forty acres of land and 100 beef cattle. They had savings in the bank, and their home was almost paid for. Now, because of medical bills their savings are gone, their farm land and cattle sold off, and their home mortgaged to the hilt. Now they owe thousands in medical bills and their credit is ruined. In Dennis Dake's words, "They turned me in to every creditor in the country. If they give a credit rating between one and ten, I'm a zero."

Dennis and Shirley have lived on their family farm near Wheaton in rural Southwest Missouri for over thirty years. The couple carefully planned and saved for their retirement on the farm, but nothing could have prepared them for what happened when Shirley fell ill and their health coverage failed to protect them from financial catastrophe.

Shirley was fifty-six when she developed a blood clot in her aorta that led to a stroke, a heart attack two years later, and multiple seizures following that. Over the last seven years, Shirley has been in and out of hospitals and rehabilitation centers trying to recover her health. Dennis retired from his job at a local factory, where he worked for almost twenty-five years, to care for her.

Shirley is home now, but paralyzed. She needs regular home health care and prescription medication as well as other medical care to prevent more damage to her health. But this care is expensive, and the Dakes have already given up everything to pay for it, except their house.

When Shirley first became sick, the couple had Blue Cross health insurance through Dennis's employer, but coverage only paid for eighty percent of the medical bills. Shirley and Dennis were responsible for the rest. One year into Shirley's treatment, the Blue Cross coverage maxed out and would pay no more: the blood clot and stroke put Shirley over the policy's lifetime payment cap.

Shirley was left without insurance for a couple of months. Bills piled up, their payments fell behind, and the couple's credit rating plummeted. Now, Shirley is covered by Medicare, but the program

also pays only eighty percent of the health care costs it covers—and it doesn't cover home health care.

Missouri's Medicaid program used to help by covering four hours per day of home health care services and the hefty cost of prescription drugs for Shirley, but since last August even this help has disappeared. Like so many others, Shirley was cut from Medicaid because of budget cuts made

in 2005. Now, Shirley must pay a monthly deductible of \$478 before her Medicaid coverage kicks in, despite the fact that the Dakes' monthly income is only \$1,400.

"When the state cut out Medicaid, that just crippled us," Dennis says. "I have been the sole caretaker since they cut her from Medicaid. There's nobody else."

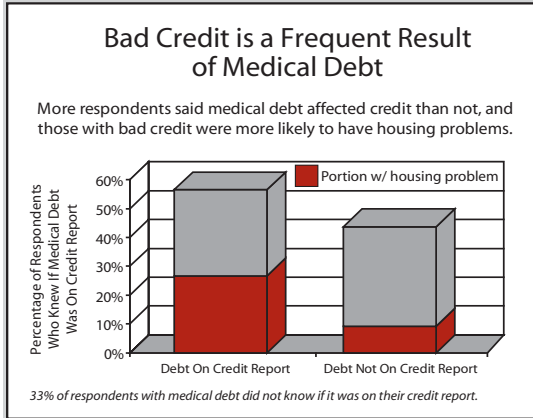
Shirley and Dennis spend nearly half of their income, \$600 a month, on their mortgage payment, and \$500 on medical expenses, leaving almost nothing for food and other expenses. Dennis and Shirley depend on their friends, family and their adult children to help them out in times of greatest need. The rest of the time, the couple has to stretch to make it. Dennis explains

that in the winter, "we can't afford to heat [our home], so we buy propane for \$179 for 100 gallons and heat one room. It will last two or three weeks if it's real cold."

After raising four children, working in the factory and on the farm, scrimping and saving, the edge of financial ruin is the last place Shirley and Dennis thought they would be at this point in their lives. This experience has left Dennis with little hope for the future: "Old people are disposable, just like the razors you buy."

While A Third Of The People Surveyed (33%) Did Not Know Whether Medical Debt Was On Their Credit Report, Of Those Who Did Know, Over Half (56%) Said It Damaged Their Credit Rating.

Damaged credit directly causes housing problems including preventing people from qualifying for a home mortgage and renting an apartment. About three-fourths (74%) of respondents with housing problems who knew whether medical debt was on their credit report said that it was. Bad credit can also be a barrier to employment and auto and home insurance. The effects of bad credit linger: a delinquent account can remain on a credit report for seven years.





Name: Bettye and Leon Pulley
Age: 60 and 66
Occupation: Homemaker and former factory worker, and city humane officer
Hometown: Kennett
Medical Debt: \$3,000

Bettye and Leon Pulley live in Kennett, the largest town (population 11,000) in the Southeast corner of Missouri known as the Bootheel. The Bootheel is an area known for economic hardship: twenty percent of the population lives in poverty. It is a place where young people tend to grow up and move away for better opportunities, leaving a graying population and communities with disproportionately high numbers of elderly and disabled people.

Bettye, 60, and Leon, 66, raised seven children in Kennett and have twenty-four grandchildren. Three of their adult children left the region in search of better paying jobs. The others remain in the Bootheel raising their families and encountering many of the same challenges that Bettye and Leon have faced for years.

Leon served in the Army and National Guard, and now works for the City of Kennett as an animal control officer. After thirty-one years on the job, his annual salary is just under \$30,000. Bettye worked at the Emerson Electric plant for thirty-two years before leaving to take a county job that ended after five years.

Bettye and Leon count themselves lucky to have had continuous health insurance for more than thirty years through their employers. Bettye is now covered by TriCare because Leon was in the military. Leon has private insurance and Medicare. But they still have deductibles and co-pays to worry about.

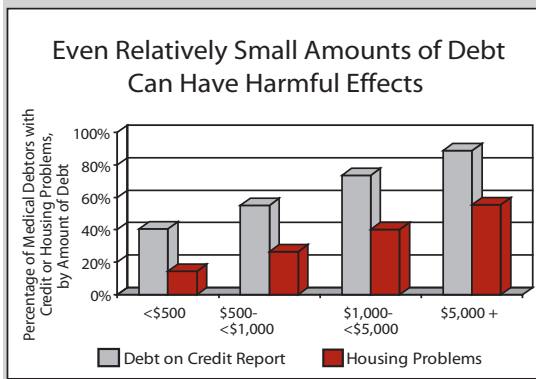
When the Pulleys' children were young, insurance covered the costs of the family's medical care. Health care costs were less of a problem while the kids were growing up even though one son had type 1 diabetes and their daughter had serious asthma, because the costs of living were lower. But as Bettye says, "The costs of living, medications, doctors' visits, and lab work—all of that elevated over time, just like the price of gas."

Now, chronic health problems have resulted in almost \$3,000 worth of medical debt—a relatively small amount—but enough to ruin their credit rating. Although Bettye and Leon are grateful that no major illnesses have struck the couple, the cost of preventative care is more than they can keep up with on their gross monthly income of \$3,170.

Over the last few years, doctors diagnosed both Bettye and Leon with type 2 diabetes. They can control the diabetes by using a glucose meter to measure blood sugar and by taking prescription medication to keep their blood sugar in a healthy range, but prescription costs, insurance deductibles and co-payments for doctor visits have added up over time. The prescription co-pays alone are almost \$200 a month.

Even Small Amounts Of Medical Debt Can Destroy A Family's Credit Rating.

For those in St. Louis—as elsewhere—even relatively small amounts of medical debt put people at risk of housing problems. In the survey, 15% of people with medical debt under \$500, and 27% with debt between \$500 and \$1,000, reported resulting housing problems.



Bettye sometimes has to borrow money to pay for prescriptions and co-pays and sometimes has to let medical bills go unpaid. The household bills—utilities, heat, phone—often seem more pressing and by the time these bills are paid there is little money left over to pay the medical bills.

As a result, medical debt has hurt the Pulleys' credit rating, preventing them from getting loans to buy a car or repair their house. In 2002, Bettye's 1995 Ford Taurus

broke down, and she tried to purchase another car to replace it. In rural Dunklin County, a car is a necessity even for basic errands—Bettye must drive 55 miles just to go to her doctor's office. Unfortunately, Betty was unable to secure a loan to purchase another newer car. Instead, she downgraded to a 1992 vehicle.

In 2003, a hailstorm damaged the Pulley's roof causing it to leak. But their bad credit rating—again, the result of unpaid medical bills—meant that Bettye and Leon could not get a loan to repair their roof. The estimated cost of the repair is \$3,000, but Bettye and Leon do not have the money. Without a home improvement loan, "We've just patched here and there," Bettye sighs, "but we can't afford to have it redone."



Name:	Christine Masson
Age:	46
Occupation:	Union organizer and former state social service worker
Hometown:	Bonne Terre
Medical Debt:	\$5,000

On March 14, 2002, while on her way to

work, Christine Masson’s car was hit head-on by a runaway tractor trailer. Doctors said it was a miracle that she survived the impact: the collision crushed her right foot, wrenched her back, and blew out her left knee. Her recovery has been long and slow, but fortunately Christine’s health insurance through her job with the Missouri State Workers Union and Workers’ Compensation covered most of her medical expenses. Still, co-payments and deductibles left Christine \$5,000 in debt to doctors, hospitals, physical therapists, and pharmacies.

Christine's injuries were so severe that she was unable to work for seven and a half months. Workers' Compensation disability payments helped, but they only covered two-thirds of her salary—cutting her monthly gross income from \$2,417 to \$1,611. By January 2004, when Christine needed follow-up surgery to replace the knee injured in the accident, her Workers' Compensation and sick leave had run out. This time, the three months medical leave needed for recovery were unpaid.

To make ends meet, Christine began charging medical and living expenses on her credit cards. "I paid off the medical bills by paying less on other bills and putting more on the credit cards." She continues, "I began to borrow from Peter to pay Paul." High interest rates on the credit cards—14.9%—made matters worse, compounding her debt until she owed almost \$40,000 to credit card companies.

Christine borrowed \$37,000 against her home to pay down the credit cards and other debt that piled up after her injury, increasing her home mortgage from \$55,000 to \$92,000. Before the accident, Christine had good credit and affordable mortgage payments: she paid \$300 per month and had a 7% fixed interest rate on a fifteen-year loan. Now, she has a thirty-year loan and her monthly payments have more than doubled to \$718.27. The best interest rate she could get was a variable 8%, leaving her fear-

ful that she's likely to end up with dramatically higher payments.

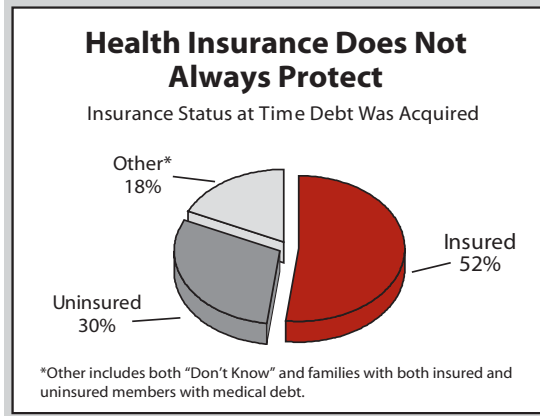
The prospect of incurring more debt led Christine to delay seeking medical treatment for a condition unrelated to the accident. Doctors have warned her about a pre-cancerous condition in her uterus and recommended a hysterectomy. Incredulous, Christine exclaims, "How could I afford another two months or six weeks without pay? That's crazy! I don't know where I would get the money."

She worries that without treatment the condition will worsen and eventually cost more time and money and result in greater debt—the exact problem she encountered when she delayed her knee surgery because she had no more sick leave.

Christine questions how much protection health insurance really provides: "I am lucky to have a health care plan, but the continual cost makes me wonder what is fair. Ten years ago, co-payments were reasonable, but now they are becoming unaffordable. I know in the next year I will be required to have another surgery. Therefore, I will be without pay for a period of time and also will have a deductible of \$1,500. This is very scary, and I often wonder how I can do it. Health care that we used to count on as being a benefit now places increasing demands on an already tight budget."

Health Insurance Does Not Always Protect From Medical Debt.

In St. Louis more than half (52%) of survey respondents who reported medical debt had health insurance at the time the medical debt was incurred.



“I am lucky to have a health care plan, but the continual cost makes me wonder what is fair. Ten years ago, co-payments were reasonable, but now they are becoming unaffordable.”



Reflections of a Realtor and Housing Specialist

Temeshia Qualls is a realtor who helps people buy and sell their homes. With Masters Degrees in Social Work and Public Health, Temeshia is also a housing specialist working with low and middle income clients who need assistance finding affordable apartments. Temeshia sees a lot of medical debt problems. “It comes up all the time. Medical care is a necessary expense that most people are not able to plan for or prevent—even when they have insurance.”

Temeshia notes that “one of the unique things about medical bills, unlike credit card bills or home loans, is they only hurt credit because they do not show up on credit reports until they are referred for collection.” Medical bills are usually only reported when they are delinquent, and then they appear as bad marks that hurt the credit scores. Credit card companies and department stores report to credit bureaus when people are faithfully and timely paying an account, and this helps a person build a good credit rating. However, timely payments on medical bills do not get reported to credit bureaus.

One trip to the doctor can result in two, three or more medical bills—for the doctor, the pharmacy, the lab work, and so on—all of which may end up being reported to the credit bureau. Medical care is not like buying a car where there is only one account. Medical care involves many different providers and many different bills. Multiple bills for the same visit can appear as multiple blemishes on a credit report.

Often, Temeshia’s clients are shocked to find out they owe a hospital, doctor or lab. Typically, people think that their insurance took care of the

bills. They have no idea their insurance did not pay and that the unpaid bill was referred to a collection agency.

“The other thing about medical debt,” Temeshia says, “is you can’t tell by just looking at someone’s credit report whether a late or unpaid bill is for a medical problem or something else.” Typically, it is the collection agency that reports an overdue

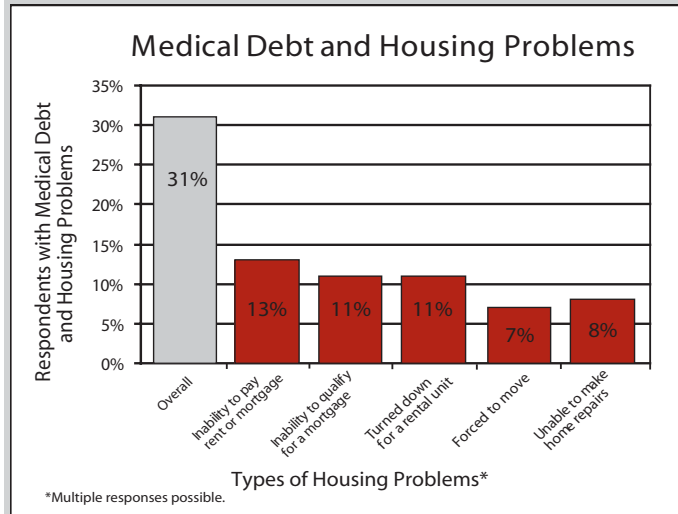
medical bill to the credit bureau and the credit report lists the bill under the name of the collection agency, not the medical provider. “One can call and find out who the collection agency is collecting for, but few lenders or apartment owners are willing to spend that much time and effort.”

“People with medical debt can hit a brick wall,” Temeshia says. “Medical debt can cause people to get turned down for home

loans or rental units. But unpaid medical bills can also throw people into the ‘subprime’ category with higher interest rates and fees. Instead of getting a home loan at 5%, the person may be charged 10%. Instead of being able to qualify for a credit card at 11%, they have to pay 20%. In the rental market, they may have to put a larger deposit down or pay more for rent every month.”

Medical Debt Can Lead To A Variey Of Housing Problems.

The most frequently reported problems were inability to pay rent or mortgage (13% of respondents with medical debt), inability to qualify for a mortgage (11%) and being turned down for a rental unit (11%). Respondents also reported being forced to move (7%) and being unable to make home repairs (8%).



“I’ve seen people in the most destitute situations where medical debt has ultimately caused them to be unable to qualify for a market rate rental or caused them to lose their home due to foreclosure.”

Discussion

This survey about the causes and consequences of medical debt is the first from which Missouri-specific findings can be drawn. While the survey was administered only in the St. Louis area—St. Louis City, and St. Louis and St. Charles counties, the personal experiences of other Missourians confirm that the problems the survey identifies are not unique to the St. Louis area. The St. Louis survey data and personal stories corroborate a growing number of national and regional studies by the Commonwealth Fund, the Kaiser Family Foundation, The Access Project and others that find medical debt to be a widespread problem.

Over half (53%) of low to moderate income workers surveyed in St. Louis had unpaid medical bills—a finding that is consistent with national studies. The Commonwealth Fund’s 2003 Biennial Health Insurance Survey reported that 53% of adults with incomes up to \$35,000—the income range of almost all the St. Louis survey respondents—reported problems paying medical bills.³

While lower income families and those with chronic illnesses have the most difficulty paying medical bills, medical debt problems sweep across all income levels. The Commonwealth Fund survey reported that two of five adult Americans (41%) had problems paying medical bills in 2003.⁴ A 2005 Kaiser Family Foundation survey reported that nearly one quarter (23%) of adults had trouble paying medical bills.⁵

Medical bills are not just a problem for the uninsured. More and more, people are discovering that health insurance does not adequately protect them when they need medical care. Over half (52%) of St. Louis survey respondents who reported medical debt had health insurance at the time the medical bills were incurred. Nationally, across all income levels, the Commonwealth Fund found that a staggering 70% of people with medical bill problems report being insured at the time of treatment.⁶ While medical debt problems among the insured are sometimes the result of an illness or injury that leads to breaks in both employment and health insurance, inadequate health insurance also plays an important role in medical debt.⁷

Less comprehensive health insurance puts people at higher risk for medical debt problems.⁸ Insured adults who must pay more out of pocket costs are significantly more likely than others with insurance to have medical bills. High deductibles (\$500 or more), annual premiums costing more than 10% of income, lack of prescription drug coverage, insurers’ refusal to pay for care, and caps on treatments are all linked to increased medical bill problems and medical debt.⁹

Having medical debt hurts one’s access to care. The Commonwealth Fund found that adults who had medical bills were three times more likely than those without debt problems to go without needed care (63% vs. 19%).¹⁰ People who owe money to medical providers are much less likely to fill a prescription, see a specialist when needed, or visit a doctor for a medical problem, and are substantially more likely to skip needed tests, treatment, or follow-up care.¹¹ Access barriers can aggravate health issues, and, ultimately lead to more costly treatment.

As the personal stories in this report illustrate, people with medical bills struggle to pay them: they work overtime, deplete their savings, borrow money from family and friends, refinance homes, take out loans, and charge medical care on credit cards. The Commonwealth Fund reports that among adults with medical bills,

over a quarter (27%) were unable to pay for basic necessities, such as food, heat or rent because of medical bills; close to half (44%) reported using all or most of their savings to pay medical bills; and a fifth (20%) took on large credit card debt or a home mortgage to pay off their medical bills.¹²

As people struggle to pay their medical bills, it frequently takes a toll on their housing—nearly a third (31%) of those surveyed in St. Louis said that medical debt resulted in housing problems. As the stories in this report illustrate, families use their rent and mortgage money, take out home loans, and move in with friends and families to try to pay off medical bills. The financial pressures caused by medical bills can result in eviction and foreclosure. Some families refinance their homes to pay off medical debts, while others are turned down for apartments and home loans because of unpaid medical bills.

Medical debt also takes a toll on medical providers: When consumers cannot pay their bills, providers have to absorb the loss or try to shift these costs to other payers.¹³ In Missouri, hospital bad debt—amounts that cannot be collected from patients—almost doubled between 1992 and 2001.¹⁴ The Missouri Hospital Association (MHA) reported that this increase is due in large part to employers shifting higher health care costs to employees through increasing co-payments and deductibles. The MHA asserts that “Patients now have co-pays and deductibles beyond their ability to pay.”¹⁵

In some cases, providers write off overdue accounts as bad debt or charity care, and the matter goes no further. All too often, though, unpaid medical bills are reported to credit bureaus where they damage credit ratings. While a third of St. Louisans surveyed did not know whether medical debt was on their credit report, of those who did know, over half (56%) said medical debt damaged their credit rating. Not only does poor credit make it harder to qualify for loans and credit, but low credit scores push consumers into higher interest loans with higher finance charges, increasing the financial pressure caused by medical costs.

Medical debt creates some special problems within the credit scoring system. First, medical bills only hurt credit ratings, they do not help them. Credit card companies, department stores, and mortgage lenders routinely report timely payments to credit scoring agencies, helping consumers build good credit ratings. Medical bills, on the other hand, only get reported to credit agencies when people fall behind—consumers never get credited for paying their medical bills on time.

Second, even a few unpaid medical bills can hurt a credit score. Credit scoring agencies count each reported unpaid bill as a “bad hit” and the total number of “bad hits” pull down a consumer’s credit score. Since medical care typically results in multiple bills—from the doctor, the lab, the pharmacist, the rehab clinic—the combined effect of several, even small, medical bills can quickly ruin a credit score. Among St. Louis survey respondents, nearly half (47%) owed two, three or more medical care providers.

When overdue accounts are referred to collection agencies, consumers are frequently pressured to put medical debt on credit cards or to take out loans to pay overdue bills. Using credit cards and loans to finance medical treatment often provides temporary relief, but it can result in hefty interest payments that escalate the cost of medical care and put additional financial pressures on families.

When medical bills are sent to collection agencies or attorneys, consumers may ultimately find themselves in court and subject to legal judgments that garnish wages, attach bank accounts, place liens on homes, or even force foreclosure.¹⁶ Medical expenses and lost income due to illness or injury factor into almost half of all personal bankruptcies.¹⁷

Recommendations

What can policymakers do about the fact that many working families cannot afford to pay their medical bills and end up with serious financial problems, their credit ruined and housing choices compromised? Medical debt seems complicated because it involves both front-end issues—financing health care through insurance—and back-end issues—the consumer credit system and billing and collection practices. While the survey data and real life stories clarify that both front-end and back-end solutions can ameliorate the problems caused by medical debt, a remaining fundamental issue is assuring that consumers have health insurance that is both affordable and adequate.

Insurance

Policy makers need to address the problem of *underinsurance* as well as *uninsurance*. In Missouri, as elsewhere, people with insurance struggle with medical debt—it is not just a problem for the uninsured. Health insurance is inadequate when out-of-pocket costs—deductibles, co-payments, bills for uncovered services—leave families owing medical bills that are unrealistically high when compared to their income and assets.

Increasingly, insurers are marketing insurance policies with higher consumer cost-sharing that provides less, rather than more, protection for families. Many of the new health insurance products—health savings accounts combined with high deductible plans, and limited benefit policies—are specifically designed to pass more of the costs of health care to the consumer. These will likely amplify the problems of medical debt documented in this report.

Policy makers should reject proposals to shift more of the costs of care to consumers because this will exacerbate medical debt problems and hurt consumers and providers. The most recent policy approach to containing health care costs is “consumer driven health care” which posits, as the head of the Washington-based Center for Health Transformation testified to Missouri’s Medicaid Reform Commission, that “People would behave differently in the health care marketplace if it were their dollars at stake.”¹⁸ The cornerstone of consumer driven health care is shifting more of the costs of health care onto consumers.

Missouri’s Medicaid Reform Commission Report embraced a number of the consumer driven health care proposals for cost shifting to patients. The Report recommends creating a state funded plan to market high deductible individual insurance policies that cover only a few specified benefits. It also recommends that the state’s employee insurance plan offer high deductible Health Savings Accounts (HSAs) to state employees. And, finally, the Report recommends higher cost sharing for Medicaid recipients through tiered co-pays.¹⁹

Shifting more of the costs of medical care to consumers is not a viable solution for controlling health care costs. Health care cost containment requires systemic policy reforms that address the real cost drivers—increases in pharmaceutical costs, high administrative overhead, and the costs of new technologies. Moreover, advocates of this approach do not appreciate the financial burden that families already bear and the devastating impact of medical debt.

As the personal accounts in this report show, consumers' dollars are already at stake. The issue is not that insured patients do not pay for care, the problem is that many people faithfully pay their health insurance premiums and then face financial catastrophe when their health insurance coverage fails to protect them from financial ruin when they get sick.

Policy makers should promote health insurance plans that protect families from financial disaster: out of pocket costs should be reasonable in relation to family income and assets. State policy makers should develop standards for adequate, as well as affordable, health insurance coverage. Affordability standards typically focus on premium costs. Adequacy standards should focus on assuring that total out of pocket costs are reasonable as a proportion of family income.

Missouri law already limits the amount of patient cost sharing that HMOs may impose. HMOs are only allowed to impose co-payments: no deductibles or other types of cost sharing are permitted. Co-pay amounts may not exceed a fixed percentage of the cost of the services.²⁰ But cost-sharing standards should not be benchmarked solely to the cost of care and should not be limited to HMO policies.

Cost sharing standards should correlate to the policy holder's income and be designed to assure adequate as well as affordable insurance. A \$1,000 deductible has quite different financial consequences for a worker earning \$35,000 per year compared to one earning \$100,000. Some researchers have suggested a benchmark of ten percent of income for health insurance premiums and cost sharing as a realistic figure for most Americans, with a lower figure—five percent or less—for low wage workers.²¹

Adequacy standards are not an unreasonable requirement to place on the state's robust and highly profitable HMO and health insurance industry. Missouri's HMOs reported a nearly 300% increase in net income from 2000-2004, with net earnings of over 207 million dollars in 2004.²² Controlling health care costs requires holding health insurers accountable for designing not only affordable, but adequate health insurance products.

Employers can help reduce the burden of medical debt by designing their health plans so that coverage is adequate and out of pocket costs are reasonable in relation to employee earnings, particularly for lower wage workers. A Hewitt Associates survey of 500 employers reported that a fifth (21%) of employers have already begun using a tiered premium system. Tiered systems mitigate the cost burden for lower wage workers because lower paid employees pay lower premiums and higher wage workers pay more. For example, Wachovia uses four salary tiers: less than \$30,000, \$30,000-\$49,999; \$50,000-\$99,999, and \$100,000 or greater. Those with lower salaries pay less than those with higher salaries.²³

Saint Louis University reduces the out-of-pocket costs for its lower wage workers by paying the employee's share of the premium for workers earning less than the St. Louis living wage level which is \$25,000 for 2006. While the University offers employees a choice of three health care plans, it pays to enroll these lower wage workers in an HMO option that charges the least out-of-pocket costs: the plan has no deductible, and the only services with co-pay charges are physician visits (\$10-\$20) and prescription drugs (\$10-\$40).²⁴

Public policy makers need to assure that working families in Missouri have access to adequate public insurance when illness and injury cause job loss and loss of employer-sponsored health insurance. State administered public insurance programs, like Medicaid and Workers' Compensation, need to interface well with both employer-provided health insurance and federal programs like Medicare to prevent gaps in health

insurance coverage that contribute to medical debt problems. Public health insurance programs, like private insurance, need to offer not only affordable premiums but adequate coverage with reasonable cost sharing in light of limited incomes.

Working families need access to adequate disability insurance as well as adequate health insurance coverage. Very often medical bills spiral up as family income spirals down because of illness or injury. Individuals need protection from wage loss due to disability. This requires assessing the extent to which private disability insurance, Workers' Compensation coverage and the Social Security Disability Insurance system work in tandem to provide adequate coverage for both short-term and long-term disability.

Billing and Collection Practices

Health care provider billing and collection policies should protect consumers who are making a good faith effort to pay their bills from being reported to credit bureaus and collection agencies. Medical debt creates a rippling negative effect on families when providers and collectors report it to credit-scoring agencies. Poor credit can prevent families from obtaining home and car loans, and subject them to higher interest rates. Medical debt also creates problems for the health care financing system. When consumers cannot pay their bills, providers have to absorb the loss or try to shift these costs to other payers.²⁵

Many hospitals have revamped their billing and collection practices to offer payment plans and reduce their referrals to collection agencies and credit-reporting agencies. But a larger conversation is needed that includes physicians, labs, pharmacists, and others in identifying 'best practices' that help providers collect what is due to them without throwing families into a cycle of bad debt and ruined credit.

Consumer Credit

Providers and consumers should begin a conversation about medical debt and credit cards. Medical debt compounds quickly when it ends up on credit cards with double-digit interest rates. While interest payments exact a large toll on consumers, money spent on interest goes to the lending industry, not to medical care providers. It would be useful to explore creative ways to ensure that providers are paid for services without pushing consumers into credit card debt.

Credit scoring organizations and lenders should consider how medical debt can be identified and should be evaluated in credit scoring and lending decisions. Some lenders and credit-scoring organizations treat medical debt differently from other unpaid bills because it is "atypical and nonpredictive" of overall credit worthiness.²⁶ However, medical debt can be hard to identify when it gets consolidated into credit card balances and home equity loans, or is owed to the collection agency rather than the health care provider. Policy makers should engage the credit scoring and lending industries in exploring more effective ways to prevent medical bills from harming people's credit scores.

Conclusion

Medical debt is a real-life problem for working families in St. Louis and elsewhere in Missouri. This and other studies confirm that medical debt is widespread, causing hardships not only for those who are uninsured but also for those who have insurance.

The profiles in this report tell the human story of medical debt—medical bills go unpaid not because families do not want to pay their bills, but because families struggle to meet all their financial obligations often putting medical bills in front of other necessities like housing.

A range of actions by private actors—medical care providers, the consumer credit industry, and employers—can ameliorate some of the causes of medical debt problems. But policy makers need to address the fundamental issue facing health care financing: consumers need access to health plans that are both affordable and provide adequate coverage. Shifting costs to consumers will only exacerbate medical debt problems and will do little to control overall health care costs.



Appendix A-Methodology

The findings in this report are based on a survey conducted in January and February 2005 at St. Louis Tax Assistance Program (STLTAP) sites, a project that helps working families claim the federal Earned Income Tax Credit. The volunteer income tax sites were chosen because they provided a reliable pool of low and moderate income working people. Almost all of the individuals surveyed had incomes in 2004 at or below \$35,000. To get a cross section of St. Louis City, County and regional residents, individuals were surveyed at five locations: South City, North City, Downtown St. Louis City, Riverview Gardens, and St. Charles County.

The survey used a written questionnaire. To minimize selection bias, every person who registered for tax assistance on the survey days was invited to participate. Individuals were assured that the results would be confidential and that declining to participate would not affect receipt of income tax assistance services. The surveys were self-administered with Saint Louis University law students available to provide help and clarification as needed. The survey was written in English and Spanish, with Spanish and Bosnian speaking law students available at the sites at which non-English speaking individuals were expected.

Characteristics of Respondents

The survey was completed by 383 people. The sample was racially and ethnically diverse. About 60% of the survey residents were African American, 22% were white, and 8% identified themselves as Hispanics. Just over 8% listed themselves as multiple race/ethnicity or did not identify a race or ethnicity.

Because the STLTAP promotes the Earned Income Tax Credit, we assumed that the survey participants would fall largely within the income range eligible for the credit. This proved to be true: 37% had incomes below \$15,000; 36% between \$15,000 and \$25,000; and 22% between \$25,000 and \$35,000. Only 4% of the sample had incomes over \$35,000, beyond the range of eligibility for the tax credit.

The survey participants had household incomes representative of a large percentage of Missouri residents. In 2004, 40% of all Missouri residents had household incomes below \$35,889, and 20% of Missourians had incomes less than \$15,409. The median family income in 2004 was \$50,819. While the survey respondents' incomes were lower than the average, they still reflect the situation of a significant portion of Missourians.

Endnotes

¹ The precise wording was “Do you or anyone in your immediate family (spouse or children) currently owe money to a doctor, hospital, ambulance service, pharmacy, nursing home, in home health care service or other provider of medical care?”

² The St. Louis survey was part of a large scale survey of low and moderate income workers in seven cities who were using volunteer tax assistance sites. See, Robert W. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*. The Access Project, November 2005. Detailed findings and methodology can be found in Appendix A. Appendix B provides a detailed breakdown on St. Louis survey data.

³ Sara R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004), 17-18. The term adults refers to people ages 19-64.

⁴ Collins et al., *The Affordability Crisis*, 17.

⁵ Kaiser Family Foundation, *Kaiser Public Opinion Spotlight: The Public on Health Care Costs* (Menlo Park: December 2005), 8.

⁶ Michelle M. Doty et al., *Seeing Red: Americans Driven into Debt by Medical Bills* (New York: The Commonwealth Fund, August 2005), 4. The term adults refers to people ages 19-64.

⁷ *Ibid*, 5.

⁸ *Ibid*.

⁹ *Ibid*.

¹⁰ *Ibid*, 5-6.

¹¹ *Ibid*, 6.

¹² Collins et al., 18-19.

¹³ Allen Dobson et al., “The Cost-Shift Payment ‘Hydraulic’: Foundation, History, And Implications,” *Health Affairs* 25:1 (January/February 2006): 22-33.

¹⁴ Missouri Hospital Association, *Access and Coverage: Hospitals Set the Standard* (2005), 56-57.

¹⁵ *Ibid*, 56.

¹⁶ Lucette Lagnado, “Twenty Years and Still Paying,” *The Wall Street Journal* 13 March 2003: B1; see Lawrence W. Vernaglia, “Legal, Policy and Practical Perspectives on Hospital Discounting and Collection Policies for Uninsured and Underinsured Patients: A Primer for Board Members and Managers,” *Journal of Health Care Finance* 31:4 (Summer 2005): 54-55, explaining how Medicare rules on bad debt drive hospital collection practices.

¹⁷ David U. Himmelstein et al., “Illness and Injury as Contributors to Bankruptcy,” *Health Affairs Web Exclusives*, 24:1 (January-June 2005): W5-70.

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²⁰ 20 Mo.C.S.R 400-7.100 (2006).

²¹ Cathy Shoen et al., “Insured But Not Protected: How Many Adults Are Underinsured?” *Health Affairs Web Exclusives* 24:1 (January-June 2005): W5-291-292, W5-300.

²² Missouri Department of Insurance, “2004 Missouri Health Maintenance Organization Report,” <<http://insurance.mo.gov/reports/2004/hmo/HMOAnnualReport.pdf>> (last visited Nov. 8, 2006) (295% increase).

²³ Leah Carlson, “Employers tier health benefits by salary: Helping Low-income workers afford health coverage,” *BenefitNews.com* March 2005 <<http://www.benefitnews.com/detail.cfm?id=7186&terms=>> (last visited Nov. 8, 2006).

²⁴ Saint Louis University Medical Plans, <http://www.slu.edu/services/HR/benefits_medical.html> (last visited Nov. 8, 2006).

²⁵ Dobson et al, “The Cost-Shift Payment ‘Hydraulic’,” 22-33.

²⁶ Robert Seifert, “The Demand Side of Financial Exploitation: The Case of Medical Debt,” *Housing Policy Debate* 15:3 (2004): 793.

²⁷ U.S. Census Bureau, *American Community Survey Profile 2004 Missouri: Table 3 Selected Economic Characteristics*, <<http://www.census.gov/acs/www/Products/>>.

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