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Borrowing to Stay Healthy:

How Credit Card Debt Is Related to Medical Expenses

Cindy Zeldin
and
Mark Rukavina

BORROWING TO MAKE ENDS MEET SERIES

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Dēmos: A Network for Ideas & Action is a non-partisan public policy research and advocacy organization committed to building an America that achieves its highest democratic ideals. We believe this requires a democracy that is robust and inclusive, with high levels of electoral participation and civic engagement; an economy where prosperity and opportunity are broadly shared and disparity is reduced; and a strong and effective public sector with the capacity to plan for the future and provide for the common good. Founded in 2000, Dēmos' work combines research with advocacy—melding the commitment to ideas of a think tank with the organizing strategies of an advocacy group.

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About The Access Project

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

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Series Info

Borrowing to Stay Healthy is the second in a series of Demos publications that examine trends in household indebtedness and its impact on economic security. The first report in the series, A House of Cards, chronicled the housing boom and the subsequent refinancing wave. Other reports in the series will continue to new research and analysis on debt among low- and middle-income households, examining the driving factors behind the rise in debt and offering fresh solutions to improve households' economic stability.

Acknowledgements

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Contents

Health care costs are rising sharply, placing stress on employers, individuals, and families. As employers look to rein in benefit costs, they are increasingly turning towards health insurance options that feature greater employee cost sharing through higher deductibles, co-payments, and other forms of out-of-pocket expenses. Others are dropping coverage entirely. Financially stretched low- and middle-income families, however, can scarcely afford these higher medical expenses. To meet out-of-pocket medical expenses, many patients are turning to credit cards and accruing medical debt. The use of credit cards for medical expenses can be problematic because the resulting debt is lumped in with all other consumer debt, making this debt not only invisible as medical debt, but also subject to a maze of interest rates and penalty fees. To gain a better understanding of this phenomenon, Demos analyzed data from a national household survey of low- and middle-income households with credit card debt. Included in this survey were questions about medical expenses as a component of credit card debt and health insurance status.

KEY FINDINGS

Our findings show that low- and middle-income ho useholds who cited medical expenses as a factor in their credit card debt had higher levels of credit card debt than those who did not cite medical expenses as a factor. Overall in our survey, 29 percent of low- and middle-income households with credit card debt reported that medical expenses contributed to their current level of credit card debt. Within that group, 69 percent had a major medical expense in the previous three years. Overall, 20 percent of indebted low- and middle-income households reported both having a major medical expense in the previous three years and that medical expenses contributed to their current level of credit card debt. Throughout this report, we will refer to this group as "medically indebted." Within this "medically indebted" group,

- Forty-four percent had credit card debt higher than $10,000 and 57 percent had credit card debt higher than $5,000.
- Average credit card debt was higher for low- and middle- income households ($11,623) as compared to households without a major medical expense in the previous three years or medical expenses contributing to their credit card debt ($7,964).
- Average credit card debt was higher for those without health insurance ($14,512) than for those with health insurance ($10,973).
- Average credit card debt was higher for households with children ($12,840) than for those without children ($10,669).
- The medically indebted are more likely to be called by bill collectors than those without such medical expenses (62 percent versus 38 percent).
- Levels of credit card debt within certain demographic groups were considerably higher among those who had a major medical expense in the previous three years

and who reported medical expenses as a contributor to their current level of credit card debt as compared to those without such medical expenses:

- For low- and middle-income Americans between the ages of 18 and 34, average credit card debt was 79 percent higher ($13,303 versus $7,450).
- For low- and middle-income Hispanic households with credit card debt, average credit card debt was 64 percent higher ($9,200 versus $5,620).
- With the exception of those households earning less than $20,000 (where it was high for all households), the debt-to-income ratio was higher in each income group.

Background

Health care costs have risen precipitously in recent years, and health spending now accounts for 16 percent of our nation's Gross Domestic Product, up from 13.8 percent as recently as the year 2000.[1] The cost of health insurance continues to outpace overall inflation and wage growth,[2] placing added pressure on already stretched family budgets.[3] Over the past six years, health insurance premiums have increased by 73.8 percent, while median income has grown by only 11.6 percent.[4] A family health insurance policy is now equivalent to 18 percent of median family income, up from 8 percent in 1987.[5]

Most Americans with health insurance have coverage through their own or a family member's workplace.[6] As employers look to rein in their benefit costs, however, more are turning towards health insurance arrangements that feature greater employee cost sharing through higher deductibles, co-payments, and other forms of out-of-pocket expenses.[7] Some are eliminating coverage altogether, and the share of working-age adults covered by employer-sponsored health insurance is in decline.[8] Public programs like Medicaid are not growing to meet the gap,[9] individual health insurance policies can be prohibitively expensive,[10] and the number of uninsured Americans continues to creep upward. In 2005, nearly 47 million Americans were uninsured.[11]

Uninsured Americans are particularly vulnerable to medical bill problems and to medical debt,[12] but such struggles are far from limited to the uninsured. According to a recent survey, a quarter of Americans have problems paying medical bills, and, among this group, over two-thirds have health insurance.[13] Numerous studies have found that large numbers of both insured and uninsured Americans have difficulty paying medical bills and are even falling into debt.[14]

Medical debt is a growing problem with severe consequences for both access to necessary health care services and financial stability: Recent research has found that about 29 million adults have medical debt;[15] that privately insured adults with medical debt are more likely than those without debt to skip recommended treatments, leave drug prescriptions unfilled, and postpone care due to cost;[16] that roughly half of all personal

bankruptcies are due in part to medical problems;[17] and that even relatively small levels of medical debt can have major consequences on financial security.[18]

There are several reasons why health insurance doesn't always offer sufficient protection against high medical expenses. Because health insurance is tied to employment, a serious medical condition can have the effect of limiting the ability to work, earn income, and remain on an employer-sponsored health plan. Lapses in health insurance are strong predictors of medical debt.[19] In general, the trend for health insurance policies has included higher deductibles and co-payments for hospitalizations, office visits, and prescription drugs,[20] which, in turn, increases the financial burden for people who get sick. Medical debt can also be tied to less-comprehensive insurance.[21] As Health Savings Accounts (HSAs) and high deductible health plans grow more common, patients face higher first-dollar expenses and may become more susceptible to medical debt.

Methodology

To gain a better understanding of medical expenses as a component of credit card debt, Demos analyzed data from a national household survey that we commissioned in conjunction with the Center for Responsible Lending in 2005. The survey consisted of 1,150 phone interviews with low- and middle-income households whose income fell between 50 percent and 120 percent of local median income—roughly half of all households in the country. In order to participate, a household had to have credit card debt for three months or longer at the time of the survey. Twenty-six percent of the low- and middle-income respondents reported having credit card debt for at least three months. The question "Do you or your spouse have any credit card debt; that is, money due on credit cards that you did not pay off in full at the end of last month?" was used to identify households with revolving credit card debt. The margin of error for the survey is plus or minus three percentage points for total respondents. Overall survey findings on indebted low- and middle-income households as well as more detailed information about the survey's methodology can be found in the report "The Plastic Safety Net: The Reality Behind Debt in America."

To identify the role of medical expenses, the survey asked respondents questions about their medical expenses, health insurance status, and whether medical expenses contributed to their current level of credit card debt. Most of the findings in this report look specifically at the subset of households reporting that medical expenses contributed to their current level of credit card debt and who reported a major medical expense in the previous three years.

Findings on Medical Expenses and Credit Card Debt

Twenty-nine percent of indebted low- and middle-income households reported that medical expenses contributed to their current level of credit card debt. Within that group, 69 percent also reported a major medical expense in the previous three years. Overall in the survey, 20 percent of indebted low- and middle-income households reported both having a major medical expense in the previous three years and that medical expenses contributed to their current level of credit card debt. Throughout this report, we refer to this group as "medically indebted." The term "non-medically indebted" refers to survey respondents with credit card debt who did not have a major medical expense in the previous three years and did not report medical expenses as a contributor to their current level of credit card debt. It is possible that some respondents classified as "non-medically indebted" in this report have medical debt outside of their credit card debt. Similarly, "medically indebted" respondents may also have other forms of medical debt in addition to credit card debt. That information is outside the scope of this survey.

Table 1: Mean and Median Credit Card Debt Among Medically Indebted* by Age, Income Level, and Race/Ethnicity

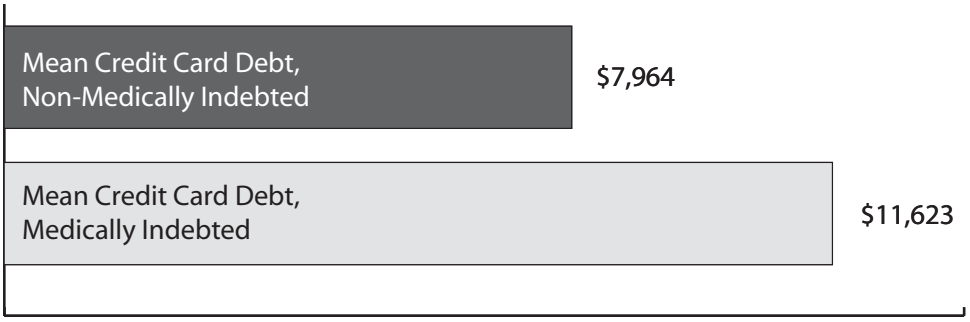
	Mean	Median
All	$11,623	$7,000
By Age		
18-34	$13,303	$6,150
35-49	$10,500	$8,000
50-64	$12,515	$7,000
65+	$6,823	$4,000
By Income Level		
Less than $35,000	$8,774	$5,000
Between $35,000 - $50,000	$12,429	$6,600
Greater than $50,000	$13,583	$7,800
By Race/Ethnicity		
Non-Hispanic Caucasian	$11,971	$7,800
Hispanic	$9,200	$5,000
Non-Hispanic African-American	$10,658	$8,000

*In this table, the term medically indebted refers to survey respondents who stated that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the past 3 years.

Low- and middle-income medically indebted households had higher levels of credit card debt than non-medically indebted households. Average credit card debt was 46 percent higher for low- and middle-income medically indebted households than for low- and middle-income non-medically indebted households. ($11,623 versus $7,964) Average debt was higher than median debt across each of the demographic categories examined

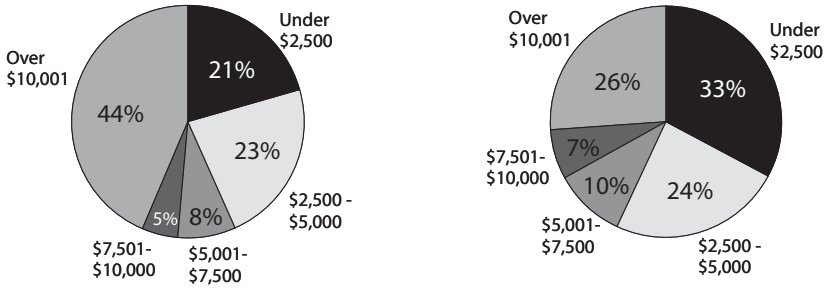
in Table 1, which is not surprising since health expenditures tend to be highly concentrated.[22] Average debt is important, however, because it reveals how financially devastating medical debt can be for those who have the misfortune of becoming seriously ill.

Figure 1. Average Credit Card Debt among Indebted Low- and Middle-Income Households



Medically indebted households had higher levels of credit card debt than non-medically indebted households. Figure 2 displays the distribution of households by level of credit card debt. Among households reporting that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the previous three years, 44 percent had credit card debt over $10,000. Among households reporting that medical expenses did not contribute to their current level of credit card debt and who did not have a major medical expense in the previous three years, 26 percent had credit card debt over $10,000.

Figure 2. Distribution of Households by Level of Credit Card Debt for Medically Indebted Versus Non-Medically Indebted Households*



*In this figure, the term medically indebted refers to survey respondents who stated that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the past 3 years. Figures exceed 100 percent due to rounding.

HEALTH INSURANCE STATUS

Average credit card debt was 32 percent higher among medically indebted uninsured households than among medically indebted households with health insurance, ($14,512 versus $10,973) which suggests that the uninsured may be more vulnerable than the in-

sured to higher levels of credit card debt in the event they incur a major medical expense.

Table 2: Average Credit Card Debt For Medically Indebted* Households by Health Insurance Status

Health Insurance Status, Medically Indebted	Mean Credit Card Debt
Currently Uninsured	$14,512
Currently Insured	$10,973
Have Been Without Insurance Sometime in the Past 3 Years	$11,812
Have Had Insurance for the Past 3 Years	$11,526

* In this table, the term medically indebted refers to survey respondents who stated that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the past 3 years.

AGE

Compared to other age groups, young adults had the highest level of average credit card debt, and the percent increase in debt for medically-indebted versus non-medically indebted people was greatest among young adults. Average credit card debt was 79 percent higher among medically indebted low- and middle-income Americans between the ages of 18 and 34 than for non-medically indebted 18 to 34 year-olds ($13,303 versus $7,450). For young adults, particularly those in their first years in the workforce, or perhaps even still in school, high levels of credit card debt can have devastating consequences on financial stability for years to come.[23]

Table 3: Mean Credit Card Debt by Age, Medically versus Non-Medically Indebted*

Age	Medically Indebted	Non-Medically Indebted	Percent Higher for Medically Indebted
18-34	$13,303	$7,450	79 percent
35-49	$10,500	$7,881	33 percent
50-64	$12,515	$8,333	50 percent
65+	$6,823	$8,466	-19 percent

*In this table, the term medically indebted refers to survey respondents who stated that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the past 3 years.

The 65 and older age group was the only age group for whom average credit card debt among those who were medically indebted was actually lower than among those who were non-medically indebted. ($6,823 versus $8,466) While adults age 65 and older have higher out-of-pocket health expenses than other age groups,[24] our findings are consistent with other research showing that adults age 65 and older have fewer problems with medical bills than the rest of the adult population.[25]

HOUSEHOLDS WITH CHILDREN

Having children appeared to be a factor in credit card debt levels among the medically indebted, while levels of credit card debt among the non-medically indebted were virtually identical for households with children and households without children. Medically indebted households with children had average credit card debt that was 20 percent higher than medically indebted households without children ($12,840 versus $10,669).

RACE/ETHNICITY

Among the medically indebted, Non-Hispanic Whites had the highest average credit card debt ($11,971), followed by Non-Hispanic African-Americans ($10,658) and Hispanics ($9,200). However, average credit card debt among medically indebted Hispanics was 64 percent higher than among non-medically indebted Hispanics ($9,200 versus $5,620).

INCOME

While those households in our survey with higher incomes also had higher average levels of credit card debt, the credit card debt-to-income ratio, an important measure of "debt stress," was highest for those households with annual income below $20,000. Table 2 displays the debt-to-income ratios for medically indebted and non-medically indebted income groups in our survey. With the exception of those households earning less than $20,000 (where the debt-to-income ratio was high both for medically and non-medically indebted households), the debt-to-income ratio was higher in each income group for those households reporting that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the previous three years.

Table 4: Debt-to-Income Ratios By Annual Household Income, Medically and Non-Medically Indebted*

Income	Medically Indebted	Non-Medically Indebted
Less than $20,000	.44	.44
$20,000 to less than $30,000	.39	.24
$30,000 to less than $40,000	.29	.19
$40,000 to less than $50,000	.30	.19
$50,000 to less than $60,000	.26	.15
$60,000 to less than $70,000	.21	.12
$70,000 and higher	.23	.13

*In this table, the term medically indebted refers to survey respondents who stated that medical expenses contributed to their current level of credit card debt and who had a major medical expense in the past 3 years. Overall in the survey, the average debt-to-income ratio was .21

Consequences of Medical Debt: Credit Card Balances, Worse Health Care, Depleted Assets

Medical debt can seriously threaten both financial well-being and access to health care services. The low-to-middle income, medically indebted households in our survey showed many signs of financial stress. Sixty-two percent of medically indebted households have been called by bill collectors, as compared to 38 percent of non-medically indebted households. Fifteen percent of medically indebted households have declared bankruptcy, as compared to 11 percent of non-medically indebted households. Among those households that refinanced their homes or took out a second mortgage, 60 percent of the medically indebted paid down credit cards with the money they received from the refinancing, as compared to 48 percent of the non-medically indebted.

Against a backdrop of declining economic stability, trends such as rising health care costs, changes in health insurance benefit design, and an ever-increasing reliance on credit cards forecast dire conditions for America's family finances.

In a recent survey of Americans with health insurance, 48 percent reported that it seemed to them as if deductible and co-pay costs were going up.[26] Indeed, this sense is confirmed by research in the health policy literature finding that the proportion of people with high out-of-pocket costs compared to income is on the rise. According to the Center for Studying Health System Change, the number of low-income privately insured people with chronic health conditions facing out-of-pocket expenses greater than 5 percent of income jumped by 50 percent between 2001, when 28 percent had out-of-pocket medical expenses greater than 5 percent of income, and 2003, when 42 percent had such expenses.[27]

Since 2003, when Health Savings Accounts were authorized by federal legislation, high-deductible health plans have become more widespread (to qualify for an HSA, one must have a high-deductible plan). Because the premiums for high-deductible policies tend to be lower than premiums for comprehensive health insurance, employers looking to hold down premium cost growth are increasingly offering these plans. Most consumers in high deductible plans, however, are not opening and funding HSAs.[28] According to a 2005 survey by the Employee Benefit Research Institute and the Commonwealth Fund, greater percentages of health care consumers in high-deductible plans spend more than 5 percent of their income on out-of-pocket medical expenses and insurance premiums. For those with household incomes below $50,000, the numbers are even starker: 92 percent of people in high deductible plans spent more than 5 percent of income on out-of-pocket expenses and premiums, while 34 percent of those with comprehensive insurance did so.[29] Medical bill problems and medical debt are more frequently reported by people in higher deductible plans.[30] As these types of plans proliferate, out-of-pocket expenses could grow even more,[31] thus increasing the potential for medical debt.

As deductibles and co-payments increase, hospitals are finding more patients unable to pay their medical bills.[32] Some hospital management analysts are expecting an increase

in self-pay patients and are bracing for higher levels of bad debt (hospital charges that are not covered by insurance and that patients are unable to pay).[33] In recognition of the evolving payment landscape and the risk of hospital bad debt, health care providers are more aggressively seeking upfront collection of co-pays and deductibles.[34] A component of this strategy is to encourage patients to use third-party lenders such as credit cards to pay for medical expenses they cannot afford, which families frequently do to meet high medical bills. In 2001, patients charged $19.5 billion in health care services to Visa cards.[35] Since out-of-pocket health expenditures have trended upward since 2001 and overall credit card use is on the rise, this figure is probably higher today. Because credit cards are frequently used to pay for medical expenses, it is likely that many estimates and analyses of medical debt actually underestimate the problem. Because medical debt that is subsumed in overall credit card debt is lumped in with all consumer debt, it is not always properly identified as medical debt.[36]

In recognition of the growing market for patient out-of-pocket costs, the credit card industry has developed "medical credit cards" designed specifically for medical expenses, which have recently entered the marketplace.[37] In some cases, health insurers and financial institutions are teaming up to offer products featuring high deductible health insurance and lines of credit to meet the increase in out-of-pocket expenses associated with the higher deductible. Several HSA servicers are now incorporating integrated lines of credit into their HSA products.[38] That there is a market for credit cards specifically designed for these out-of-pocket costs indicates that patients are having difficulty meeting these expenses. To the extent that interest rates or penalty fees are applied to these expenses when credit cards are used to meet them, patients are paying even more. In other cases, credit card companies are working in conjunction with health care providers to shift bill collection from the provider to the credit card company, and are offering incentives such as bill discounts for patients who use the credit card, particularly uninsured patients.[39] Many of these credit cards charge interest, and, like traditional consumer credit cards, a late payment can trigger penalty rates and fees, thus exacerbating medical debt.[40] In a deregulated lending environment, once medical debt is subsumed under credit card debt, it is subject to the same maze of terms, conditions, and fees to which all consumer credit card debt is subject.[41] More oversight of this burgeoning industry is needed to protect consumers from medical credit card debt.

Areas for Future Study

Low- and middle-income households are turning to credit cards to fill in gaps in health coverage and to pay for necessary medical expenses they are unable to afford. Our research shows us that indebted households with major medical expenses have higher levels of credit card debt than those without such expenses. As health insurance options featuring higher deductibles and out-of-pocket expenses become more widespread, we can expect the use of credit cards to fill in the gaps to become more common. To better understand this emerging phenomenon, additional research should be undertaken to explore questions such as:

- Among households with credit card debt reporting medical expenses as a factor, what portion of that debt is due to medical expenses?

- Do households devoting high percentages of income to medical expenses use credit cards for other basic necessities to make up for the greater share of income devoted to expenses associated with a major medical event?

- Is the use of credit cards for medical expenses more common for certain types of medical conditions that may not be covered by health insurance?

- What is the frequency of credit card use to pay medical bills in various settings such as hospitals, physician offices, and pharmacies?

- Do low- and middle-income households with high deductible health plans use credit cards to meet out-of-pocket health expenses?

- What types of interest rates and fees are patients paying on "medical credit cards?" Are consumers with medical expenses increasingly using these kinds of cards?

Policy Recommendations

Policymakers must address the twin problems of health care cost and coverage in a comprehensive manner to protect American families from financial insecurity and the deleterious health outcomes that result from the current system. We believe that the ultimate solution is a system that provides universal access to comprehensive benefits. Short of this goal, however, there are interim steps that we believe will begin to mitigate the financial consequences that are imposed on people who have the misfortune of getting sick.

DIFFERENTIATE MEDICAL DEBT FROM CONSUMER DEBT

Many Americans are having trouble meeting their health care expenses and are relying on credit cards as a means to pay their medical bills. However, debt from outstanding medical bills is unlike other forms of debt. There is growing recognition in the lending and credit community that medical debt may require special treatment. Major credit scoring organizations, such as Fair Isaac and Company (FICO), consider medical debt to be "atypical and non-predictive" of overall credit worthiness.[42]

Medical debt, like others forms of debt, is fungible. Regulators must consider ways to prevent medical debt from ruining credit records. Since lenders may have insufficient information to disregard medical debt when making a lending decision, these debts should be treated differently by medical providers. Medical providers, and their designees, such as collection agencies to which delinquent accounts have been turned over, should refrain from reporting that debt to credit bureaus.

Given the atypical nature of medical debt, no one making a good faith effort to pay their medical bills should be subject to the maze of high interest rates and penalty fees that have come to characterize the credit card industry today. Credit card issuers regularly group purchases into categories of service, and identifying health care expenses that were charged to credit cards should not be overly burdensome. Interest charges on other preferred expenses—home mortgages and student loans, for example—are tax deductible, thus mitigating the expense to the consumer of the interest charges. Methods for similarly mitigating the cost of interest charges on medical expenses for consumers should be explored.

LIMIT THE ENTRY OF MEDICAL PROVIDERS INTO FINANCIAL SERVICES

Medical providers are beginning to offer financial services to patients, transforming the patient/provider relationship into a debtor/creditor relationship. Provider-sponsored credit cards and revolving lines of credit are often offered under the guise of financial assistance. The specific finance charges and fees associated with this credit are not always readily apparent to the patient. Patients unable to pay their bills in full may feel obligated or pressured to accept the terms of credit offered by the very people or institutions that they look to for healing. Medical providers should be discouraged from moving into the financial services area.

INCREASE OVERSIGHT OF LINES OF CREDIT ATTACHED TO HEALTH SAVINGS ACCOUNT PRODUCTS

Financial services companies are jumping into the Health Savings Account market, and some are offering integrated lines of credit into their HSA products. Internal Revenue Service guidelines have authorized this practice; however, additional research and oversight are needed to protect consumers from potential interest charges that could serve as an additional disincentive to seek medical care. Particularly if a patient has a low credit score, he or she could pay high interest rates for health care services. Careful monitoring of this emerging industry is needed to protect patients.

ENSURE ADEQUACY OF INSURANCE COVERAGE

New developments in health insurance products—HSAs, high deductible plans, limited benefit policies, "consumer-driven health care"—increase individual risk and challenge the notion of health insurance. Businesses that offer coverage to employees often face double digit premium increases and have little choice but to pass along more of the cost of the coverage. This puts their employees at risk of incurring medical debt. We urge the establishment of standards for adequate coverage, including cost sharing obligations that are proportionate to family incomes.

IMPROVE SCREENING FOR ELIGIBILITY IN PUBLIC OR PRIVATE FINANCIAL ASSISTANCE PROGRAMS

Over the past few years, there has been much attention focused on health care provider billing and collection practices. Research has documented that many people eli-

gible for public programs are not enrolled in them and, as a result, incur medical debt. Health care providers could help reduce medical debt while enhancing their revenues by improving their screening of patients for eligibility for public programs such as Medicaid and State Children's Health Insurance Programs. Providers should also be encouraged to clarify and publicize their institutional financial assistance programs that are intended to expand access to care for those without resources to pay.

ENACT A BORROWER'S SECURITY ACT

We must protect consumers from deceptive credit card terms and exorbitant interest rates and fees. Fueled by steady deregulation of the industry, credit card companies increasingly charge excessive interest rates and fees, making it harder for families to get out of debt and back on the path to savings. Today there are no legal bounds to the amount of fees and interest credit card companies can charge borrowers. In addition, credit card companies, unlike other lenders, are allowed to change the terms on cards at anytime, for any reason. As a result, cardholders often borrow money under one set of conditions and end up paying it back under a different set of conditions. We recommend a Borrower's Security Act that would limit these practices and restore the balance of power in the lending relationship by prohibiting credit card companies from raising a borrower's interest rate based solely on payments to other creditors; requiring credit card companies to limit any interest rate increase to future activity on the card only and limit the amount by which interest rates can be raised; requiring credit card companies to institute a late-payment grace period; and raising the minimum payment requirement to 5 percent of a cardholder's balance to curtail excessive debt loads.

Notes

1. National Health Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary, U.S. Department of Health and Human Services.

2. Hewitt Associates, "Hewitt Associates Data Reveals Lowest U.S. Health Care Cost Increases in Eight Years," Press Release, October 9, 2006. For trend data, see Kaiser Family Foundation, "Trends and Indicators in the Changing Health Care Marketplace," Section 3: Trends in Health Insurance Premiums, www.kff.org.

3. Kevin G. Hall, "Health Care, Wages, Energy Costs Put Squeeze on Middle Class," McClatchy Newspapers, October 17, 2006.

4. Families USA, see Kaiser Daily Health Report, "Health Insurance Premium Rates Increase Faster Than Income, Study Says," October 18, 2006. The study examines premium growth from 2000-2006.

5. Reported in presentations and calculated by health economist Len Nichols based upon CPS, AHRQ, and Kaiser Family Foundation data. The 18 percent statistic is for 2004.

6. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Issue Brief No. 298, EBRI, October 2006.

7. Mercer Human Resources Consulting, "2005 National Survey of Employer-Sponsored Health Plans," see Tab 4 at http://www.dppl.com/Mercer_Bos_2006/.Also see Paul Fronstin and Sara R. Collins, "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/ Commonwealth Fund Consumerism in Health Care Survey," EBRI and the Commonwealth Fund, Issue Brief No. 288, December 2005.

8. In 2006, 61 percent of firms offered health benefits, as compared to 69 percent in 2000. See Kaiser Family Foundation, "Employer Health Benefits 2006 Annual Survey," Exhibit 2.1. In 2005, 63.8 percent of working age adults had employment-based health insurance, as compared to 68.7 percent in 2000. See Paul Fronstin, EBRI, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Issue Brief No. 298, October 2006.

9. While programs like Medicaid and SCHIP have offset some of the reduction in private coverage in the past, public programs are no longer expanding enough to compensate for the decline in employer-sponsored insurance. See John Holahan and Allison Cook, "Why Did the Number of Uninsured Continue to Increase in 2005," Kaiser Commission on Medicaid and the Uninsured, October 2006; Stephen Zuckerman and Allison Cook, "The Role of Medicaid and SCHIP as an Insurance Safety Net," Urban Institute, August 21, 2006; Center on Budget and Policy Priorities, "The Number of Uninsured Americans is at an All-Time High," August 29, 2006; and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Issue Brief No. 298, EBRI, October 2006.

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Appendix: Case Studies

Peggie S. – Tampa, Florida

Peggie lives with her husband and 16-year old daughter in Tampa, Florida. Although the family's yearly income exceeded $100,000 before Peggie fell ill, the family almost lost their home due to costly medical bills paid for with credit cards. Peggie suffered two bouts of breast cancer in one year with treatment spanning between November 2003 and April 2005. "Over two years I had 6 surgeries, ending up with a double mastectomy and reconstruction," she explains. "All the money we had coming in went to pay medial bills, for antibiotics and pain medications." While the medical treatment cured her cancer, she was left with over $40,000 in medical bills.

Peggie accumulated these bills despite having health insurance through her employer. Because she worked for a very small organization, however, the insurance was a high-deductible plan purchased in the non-group market. Most of Peggie's bills stemmed from the high out-of-pocket costs imposed by her health plan: 20% co-insurance, no drug coverage, and a $2500 deductible. The illness forced her to pay this deductible three times over three years, each time before she was able to seek care: "Before any of my surgeries the hospital would check with the insurance company, and make sure that my deductible was paid. If not, I had to pay it in full before the surgery."

Peggie also encountered unforeseen out-of-network charges for which her co-insurance responsibility rose to 40%. Although she sought care at an in-network hospital, some of the doctors working in the hospital did not accept her insurance so they were technically out-of-network. Although her illness was hard to cope with, Peggie found dealing with her insurance company to be even more of a headache: "At one point I was so frustrated I wrote to the insurance company: 'You are worse than the cancer. I can cut out the cancer but I have to work with you.'"

Peggie and her husband used up all of their savings to pay for the medical care. Nevertheless, their credit was threatened and their house almost went into foreclosure due to left over bills. They were only able to pay off the credit card debt after Peggie's parents passed away and left her some money. Peggie relates that, "During all of this we buried my mother and father, and only through the inheritance that I received from them were we able to keep our home and credit."

David B. – University Heights, Ohio

David has had type-1 diabetes since age 11—he is now 46 years old. David's diabetes and a number of on-going minor health needs necessitate regular trips to doctors and specialists. David works in the field of School Psychology and has health insurance through his employer. He does not have dental insurance, however. While David hasn't recently accumulated large medical bills, the co-payments for doctors' visits are financially difficult. "I've had to go through a lot of tests and seen a lot of different doctors and that's just additional co-pays each time. Basically, I'm going into savings and going into debt occasionally just to pay my medical bills." The bills really add up over the year: "Adding up even all my medical expenses, it's like close to 20% of my gross income." David often delays or discontinues care due to financial considerations: "The time in-between my regular appointments with my diabetes specialist or primary care, I just don't go as often as I'm supposed to…[and] I definitely discontinued treatment of my shoulder after awhile just because I couldn't afford it."

Without enough disposable income to pay for all of his medical costs out-of-pocket, David frequently uses his credit card to charge co-payments and other doctors' bills. This past year, he was forced to see the dentist despite lack of insurance coverage. He ended up putting $1500 on his credit card to pay for a filling and fix a broken tooth.

Affording prescription medications has also been a challenge. David reflects that there's only one choice of insurance companies through his employer, and yet, "so far there have been 3 different medications that I've been recommended or prescribed that are not on [the company's] formulary, and thus the only way I can get them is to pay out of pocket." One of these medications costs $8 per day, or almost $3000 per year. "[That] is 10% of my gross salary!" David exclaims.

Five years ago, David could no longer afford to pay the mortgage and upkeep on his home, so he sold it to pay off his credit card debt and went back to renting. When money becomes very tight, David has taken on additional work—and in some cases a second job—to help him keep up with on-going medical expenses.

Diane N. – Maryland Heights, Missouri

Diane was unexpectedly hospitalized for six days in July 2006 due to severe bronchitis. Despite having health insurance through her husband's employer, the family accumulated more than $4000 in medical debt. Diane owes much of this money due to co-payments and a per person yearly deductible of $2500. Together, Diane and her husband earn more than $76,000 per year. But with escalating insurance premiums and two grown daughter and a grandchild they assist financially, money is tight. "I'm angry because we're paying so much for this health insurance and we're getting, in my eyes, so little back," Diane relates. "I don't understand…I don't think our health care is that good here."

Diane pays all of her medical bills on her credit card. Because she is an accountant and bookkeeper by profession, she makes sure to pay off her entire credit card balance at the end of each month. Although she originally set up a $125 per month payment plan with the hospital, Diane was forced to scale back her payments to $20 for August and September to keep up with her credit card bills. In August, she had been able to negotiate an almost 2/3rds discount on a related doctor's bill, but she had to pay the entire discounted balance in full. Diane paid the $542.80 with her debit card, however, this payment drained much of the family's disposable income and they were unable to keep up with the original hospital payment plan. Although Diane increased her monthly payments to $80 for the rest of 2006, the hospital contacted her in December and threatened to send the bill to collections if she didn't boost her payments to $125. Fortunately, Diane was able to negotiate with the hospital billing office to continue accepting $80 per month, which is affordable for the family. Reflecting on her struggle to keep up with her medical debt and credit card payments, Diane notes that, "You have to rob Peter to pay Paul. You have to go without something else."

Because of these outstanding medical bills and the prospect of more cost sharing, the family delays care. "My husband needs a colonoscopy," Diane explains. "His mother had cancer when she was younger than he is now, and he has held off getting that done because it'll cost the $2500 deductible." Diane is also overdue for a mammogram screening: "I'm afraid that [my insurance] will not pay for it even thought it is supposed to pay 100%." She has every right to be afraid—they denied payment for a mammogram she received in December 2005, which was only resolved after 6 months of concerted self-advocacy. The insurance company never

paid a cent; eventually the hospital just wrote off the bill. Despite this victory, Diane shakes her head: "I am very tired of working so hard to get the insurance company to pay the claims and keep the health care people at bay."

Donna and Grace W. – Greenfield, Massachusetts

Donna's eldest daughter, Grace, was diagnosed with Cerebral Palsy at age 1. Grace is now seven years old. Between 2001 and 2004, Grace received numerous Botox treatments to improve her mobility—the co-payment for each outpatient treatment was $500, which quickly added up. Donna explains: "We had a financial strain because she would need to go in about every four to five months, at one point, for treatments." Grace also needed lots of costly durable medical equipment, which was sometimes not covered by insurance.

The family has maintained medical insurance through Donna's various employers over many years. Since 2003, Grace has also been covered by CommonHealth, the Massachusetts Medicaid program for disabled people. Before Grace qualified for CommonHealth, the family was left with many outstanding medical bills that were not covered by their health insurance. Donna and her spouse racked up over $30,000 in credit card debt to pay for Grace's adoption and medical care. "We typically paid off the hospital and doctors," Donna reflects, "but what happened was a kind of boomerang effect [where] we ended up putting more on credit cards because we were keeping up with the surgeons and the hospitals. We had to go into credit card debt to be able to keep things moving along for her."

The lifestyle change induced by having a child with special needs was also a terrific challenge. "I'm somebody who's kept a good credit record…but when you have a child with special needs, you think you know what's coming," Donna sighs. "But there isn't any way to truly know what it's going to be like until you're dealing with it on a day-to-day basis." Donna began working part-time and took a major pay cut so she could take care of Grace.

The family tried payment plans, but drained their personal savings paying off the accumulating bills. "The medical issues that would come up with the co-payments and the deductibles, and the durable medical goods—it just snowballed and it got way ahead of us to the point where we knew, regretfully, what we had to do to get back on track." Unable to keep up, they declared bankruptcy in 2003.

Since 2003, CommonHealth has helped the family to cover the bulk of Grace's medical bills left uncovered by their insurance. Medical costs have still accumulated, however, and they currently owe over $1000 in credit card debt. To add insult to injury, although Donna's spouse's insurance would be cheaper for the whole family, her employer does not recognize same-sex marriage. The family is forced to accept insurance from Donna's employer, which costs a very expensive $1000 per month.

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