Approved: 4/1/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on March 3, 2009, in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the committee:
Corrie Edwards, Kansas Health Consumer Coalition
Harry Cass, Private Citizen, Overland Park, KS
Roger Griffin, Private Citizen, Lyons, KS
Mary McBain, Volunteer Keeler Women's Center, Kansas City, KS
John Hooge, Attorney, John R. Hooge & Associates, Lawrence, KS

Others attending:
See attached list.

Informational Hearing on Medical Debt

Chairman Barnett opened the meeting by introducing pages Jace Bowen and Austin Best. Senator Barnett commented that the topic for the informational hearing is debt incurred due to health care costs and expenses, its ramifications, its contribution to under- and uninsured populations, etc. Senator Barnett recognized Corrie Edwards, Kansas Health Consumer Coalition.

Ms. Edwards spoke about the link to medical debt when once-healthy Kansans experience a change in health status and their savings and other assets disappear. More than 70% of medical debtors had health insurance when his/her health condition changed (Attachment 1). She cited the rising cost of care and out-of pocket expenses comparing 1980 expenses to 2003; in addition, insurance premiums for 1980 and 2003 were also described. Ms. Edwards spoke about the increasing use of loans and credit cards by consumers to pay for medical debt. Ms. Edwards described two approaches to address medical debt problems: first, to prevent debt from occurring; and second, to reduce the impact of debt by making it easier for consumers to pay their obligations. She indicated that charity care (and the communication of charity care policies to consumers) accompanied by the identification of those who are eligible for such charity care is necessary for those who have no ability to pay. Another important avenue to medical debt reduction is to allow uninsured patients to pay the same rates that insured patients receive. She indicated that several other states restrict or cap interest rates for medical debt. Ms. Edwards concluded that the Kansas Health Consumer Coalition is working to collect additional information about Kansas debt laws and provider practices to identify effective solutions for Kansas.

Harry Cass, a private citizen from Overland Park with a successful chiropractic practice, described his experience when his health changed in 1982 (Attachment 2). His health condition required medications costing over $20,000 monthly, bone marrow transplant, and chemotherapy. He lost his employment and COBRA benefits expired. He entered a High-Risk Insurance Pool with premiums of $600 monthly and out-of-pocket co-payments/deductibles of $10,000. The cost of his medical debt prevented him from caring for his family. He implored committee members to search for ways to ease the burden of medical debt for hard-working Kansans.

Roger Griffin, a third generation farmer from Lyons Kansas, shared his personal story when he contracted West Nile Virus in 2001 (Attachment 3). He indicated that his medical condition resulted in the abandonment of his farming occupation. He indicated that while he was financially responsible and had planned for the future, a medical condition (through no fault of his own) has resulted in more debt than he and his family can manage.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Minutes of the Senate Public Health And Welfare Committee at 1:30 p.m. on March 3, 2009, in Room 136-N of the Capitol.

Mary McBain, a CPA and volunteer at the Keeler Women's Center in Kansas City, provided testimony (Attachment 4) related to her experience as a cancer survivor and her role as a volunteer in assisting women navigate and negotiate medical debt. Through her volunteer work she concludes that more transparency about medical costs and providing vital information about charity care, payment plans, and other options prior to receiving care is crucial to resolving escalating debt.

John Hooge, an attorney from Lawrence, was present to share the stories of several of his clients who filed for bankruptcy resulting from medical issues (Attachment 5). He indicated that 41% of all bankruptcy cases are a direct result of medical debt. He reported reasons for medical debt result from many employers offering no insurance, self-employed Kansans have no insurance, insurance is too expense for many low-paid workers, pre-existing conditions may not be covered, and some medical conditions are catastrophic and even with good insurance, a person cannot pay remaining amounts.

Chairman Barnett announced the informational hearing on Medical Debt would conclude on Wednesday, March 11, 2009.

The next meeting is scheduled for March 4, 2009.

The meeting was adjourned at 2:30pm

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SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 3, 2009

Sean Miller — Capitol Strategies

NAME	REPRESENTING
Lindy Hermes	KID
Chris Gigstad	Federico Consulting
Mike Shields	KHI News
Anne Spiess	American Cancer Society
Kari Presley	Kearney & Associates
Connie Edwards	Ks Health Consumer Coalition
Suzanne Cleveland	KHI
Harry Kass	Citizen
Gina Maree	KHI
John Hooge	self-witness-
Mary MacBain	Self- witness
Judy Lewis	self
Anna Lambertson	KS Health Consumer Coalition
Sonia Olmos	KS Health Consumer Coalition
Tracy Russell	KS. Health Consumer Coalition
Roger Griffin	Ks Health Consumer Coalition
Cynthia Smith	SCL Health System
Charlotte Perry	Washburn Grad Student
Tammy Patterson	Washburn grad student

Donn Teske — Ks Farmers Union

KANSAS HEALTH CONSUMER COALITION

STRENGTHENING THE VOICE OF KANSANS ON CRITICAL HEALTH CARE ISSUES.

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Testimony before the Senate Public Health and Welfare Committee

Medical Debt

Corrie Edwards, Executive Director, Kansas Health Consumer Coalition

March 3, 2009

Mr. Chair and members of the committee, my name is Corrie Edwards and I serve as the Executive Director for the Kansas Health Consumer Coalition. Over the past few years, health reform has received considerable discussion in Kansas. While that debate covered many topics, there was a fundamental issue that did not receive attention. That issue is medical debt. There is no denying the link between health care and cost as one of the primary obstacles to better health outcomes. Nowhere does this link become more evident than in the experiences of once healthy Kansans whose fortunes changed when their health status changed. While I will share statistics on medical debt and policy considerations, it is just as important to hear from Kansans dealing with medical debt and the impact of that debt on their health, emotional, and financial well being.

When we hear about people with medical debt, it is not unusual to blame that person for the circumstances in which he finds himself. If only he had health insurance, this would not have occurred. While it is true that some people elect not to purchase health coverage, even though they have the means to do so, this is more the exception than the rule when it comes to medical debt. In fact, more than 70 percent of medical debtors had health insurance when the health condition developed[1]. In many cases the illness leads to job loss which in turn, leads to loss of insurance coverage. For many with insurance, the out-of-pocket costs and coverage limits lead to financial turmoil. This is particularly true for those securing coverage in the individual market. The other significant factor in medical debt is simply the high cost of care and corresponding out-of-pocket costs. In 1980, an individual spent an average of $2,253 (2002 dollars) on health expenses. By 2003, he spent $5,491 (2002 dollars). In 1980, the average individual spent $624 for insurance premiums and $123 on out-of-pocket expenses. In 2003, individual premiums increased to $1,966 and $223 for out-of-pocket costs[2]. The fee for service

[1] Doty, Michelle, Edwards, Jennifer, Holmgren, Alyssa; The Commonwealth Fund; *Seeing Red: Americans Driven Into Debt by Medical Bills*; August 2005; p. 4.

[2] Kansas Rural Health Options Project; October 2006.

Public Health and Welfare
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Attachment: 1

model that we utilized in the first half of the twentieth century is no longer practical with escalating health care costs.

How significant is the medical debt problem in Kansas? While we do not have the data to quantify the extent, there are some surveys that have been done in Kansas indicating a problem that warrants further study and action. In 2005, The Access Project (TAP) surveyed 1,058 patients at four community health centers. Two of the centers are in Wichita, one in Emporia, and one in Garden City. One of the most surprising and worrisome findings from the research was the small amount of medical debt it took to lead to financial problems. Thirty-five percent of respondents with medical debt owing less than $800 experienced trouble in paying for housing. Fifty-two percent of respondents with medical debt had difficulty in paying for housing when the medical debt was between $800 and $3,500. Seventy-two percent of respondents with medical debt exceeding $3,500 experienced a problem in paying for housing[3]. Many attempt to pay medical bills by borrowing, leading to even more tenuous financial circumstances. Borrowing may take the form of securing loans, putting the bill on credit cards, taking out a home equity loan, and borrowing against the future by taking out retirement funds. Despite these efforts, credit is often adversely impacted, resulting in more costs as interest rates are increased. What may have started as a single area of debt spirals into a financial problem impacting all of life's necessities that cannot be solved any more by eliminating the original debt source.

One of the profiles in the TAP report vividly illustrates the problem caused by a relatively small amount of medical debt. Suzanne and her husband live in Americus and are employed full-time with health insurance. Because of high deductibles and uncovered services, the family went into medical debt with three emergency room visits. One visit resulted from her husband's farm accident and the other two from a daughter's asthma attacks. With her last pregnancy, Suzanne could not afford the $1,500 deductible. A payment plan could not be agreed to and the bill went to collections. In an effort to make payments on the medical debt, the family has put other household necessities on a credit card. At one point, Suzanne resorted to a payday loan to cover her daughter's asthma medication. As a result of the compounding debt, Suzanne and her family were forced to delay health care or forgo it altogether[4].

Unfortunately, Suzanne's situation is not unique. Of respondents with medical debt, nearly four out of ten stated they didn't receive any offer of financial assistance from providers. For those who were offered help, it generally came in the form of an installment plan. Only

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[3] Pryor, Carol and Prottas, Jeffrey; The Access Project; *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security;* January 2006; p. 3.

[4] Pryor, Carol and Prottas, Jeffrey; The Access Project; *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security;* January 2006; p. 8.

fourteen percent said that their debt was discounted[5]. This is particularly important because the uninsured or underinsured may be charged significantly more for care than insured patients receiving an insurance company negotiated rate.

While patients with medical debt can be found throughout the state, it may be more prevalent in rural areas. TAP conducted another study in 2006 of farm and ranch operators throughout the Midwest. Although this study did not include Kansas, the health coverage circumstances would be similar because of the focus on family-owned farms. The researchers define financial hardship as having ten percent or more of income going to health care expenses. Under this definition, fifty-four percent of farmers surveyed experienced financial difficulties due to health care expenses[6]. For respondents who indicated financial hardship, they spent forty-two percent of their incomes on health expenses[7]. The high percentage of income going to pay health bills is particularly surprising considering that farmers have higher than average income than the American population as a whole. One of the primary reasons for high expenses is a greater proportion of farmers must secure coverage in the individual market because they are self-employed. While only eight percent of the general population gets individual coverage, thirty-six percent of farmer respondents purchased individual coverage[8]. The premiums and out-of-pocket costs average $11,200 in the individual market, compared to $5,600 for those with job-based coverage.

Several states have examined and taken action to alleviate medical debt. There are two main approaches to addressing the problem. The first is to prevent debt from occurring and the second is to reduce the impact of debt by making it easier for consumers to pay their obligations. One of the easiest ways to reduce debt is to have charity care policies in place and communicate them to patients. Hospitals receive tax benefits based on the public benefit that they provide. Having a process in place to inform consumers who might qualify for charity care saves the provider and consumer from going through a process in which the consumer has no ability to pay. If a patient accumulates debt, steps should be taken to allow them to pay the debt. This includes charging the patients the same rates that insured patients receive. Collections processes need to be revamped to reflect the fact that medical debt is not

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[5]Pryor, Carol and Prottas, Jeffrey; The Access Project; *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security;* January 2006; p. 2.

[6] Pryor, Carol and Prottas, Jeffrey; The Access Project Issue Brief; 2007 Health Insurance Survey of Farm and Ranch Operators; September 2008; p. 1.

[7] Pryor, Carol and Prottas, Jeffrey; The Access Project Issue Brief; 2007 Health Insurance Survey of Farm and Ranch Operators; September 2008; p. 1.

[8] Pryor, Carol and Prottas, Jeffrey; The Access Project Issue Brief; 2007 Health Insurance Survey of Farm and Ranch Operators; September 2008; p. 1.

discretionary debt. Several states restrict the amount of interest that may be charged on medical debt and require providers to allow consumers to work out a payment plan based on ability to pay.

The Kansas Health Consumer Coalition will be working to collect additional information about Kansas debt laws and provider practices so that we can identify solutions that will be most effective in Kansas.

Thank you for the opportunity to speak with you about this important issue. I look forward to working with you on this in the future.

Testimony from Harry Kass

Mr. Chairman and Members of the Committee:

It is an honor to be presenting testimony today. My name is Harry Kass and I reside in Overland Park. I am a former Chiropractor. I wish to testify today because my experience, while unique in certain respects, is not unlike that of thousands of other hardworking Kansans.

In 1982, at the age of 22, I received the frightening diagnosis of leukemia. The leukemia treatment was arduous and expensive; at one point, the medications used to fight the cancer that was ravaging my body ran as high as $20,000 a month. However, that I am here today stands as a testament to the efficacy of those treatments.

Approximately 15 years after a bone transplant, 200 blood transfusions, and numerous rounds of chemotherapy, I was diagnosed with Hepatitis C in the 1990's. This was through no fault of my own and was an unfortunate complication of blood transfusions. By 2003, my poor health resulted in a loss of full time employment. Shortly thereafter, my COBRA benefits expired and I was forced to enter the state's high risk pool, as my pre-existing conditions left me with no other alternative. At that time, my monthly premium was almost $600 a month and I had a $3,000 deductible.

I was unable to balance the thousands of dollars a month in medications that I required, on top of the numerous hospital procedures I endured. In 2004, I declared bankruptcy, having tens of thousands of dollars of unpaid medical bills.

In 2008, my monthly health insurance premium increased to $760. I successfully negotiated to lower my premium to $475 a month, but my deductible rose to an astronomical $5,000. Nearly five years after filing for bankruptcy, I am again mired in debt, doling out $350 a month for medications and being strapped with an unreasonable deductible.

I am an educated man. I hold a Doctorate of Chiropractic. I do my best to live within my means. I don't make unnecessary purchases and drive a little Mazda. I hold down 3-4 jobs to get by and responsibly pay my bills and care for my child. Yet unforeseen circumstances beyond my control have irreversibly altered my life and made my medical care unaffordable and therefore insufficient.

The inability to afford medical care hurts more Kansans than just the patient. Hospitals are being shortchanged, health providers are not receiving payment for their essential services, and as a result, costs are rising for all of us. The current health care system is spiraling out of control.

I urge you to consider medical debt to be a serious symptom of an inadequate system, rather than the fault of responsible and hardworking Kansans. We work hard, believe in doing what's right, but are being strapped with costs that we cannot manage. Please help us and in doing so, help the entire state.

Testimony from Roger Griffin

Mr. Chairman and Members of the Committee:

Thank you for allowing me to share my testimony with you today. My name is Roger Griffin and I am a 3rd generation farmer from Lyons. For forty years, I farmed the land my father had farmed. In 2001, I contracted the West Nile virus, probably from a mosquito bite, and developed complications. I thought I had good health insurance until I had to use it.

By 2006, my out-of-pocket expenses for deductibles, co-pays, prescription medications, high dollar tests, and out-of-network charges for specialists had mounted to more than $100,000. At one point, I fell behind almost $1,000 in medical bills for a clinic where I was receiving care. The clinic administrators sent my unpaid bills to collections and refused to see me for further treatment. We scraped the money together and paid the bill, but they still refused to treat me. The only other option for me and other folks in my county was a clinic in Wichita, almost 75 miles away.

When I first got sick in 2001, I thought it was the flu. My joints ached and I came down with a fever. I was tired all of the time and couldn't work. My doctor thought I had West Nile but since the virus was relatively unknown then, public health officials said the diagnosis had to be confirmed. This entailed rounds of expensive tests. My wife, Susan, was working at a major national corporation doing business in Rice County, so we had health insurance, but it only covered a percentage of the costs. The out-of-pocket costs just kept adding up. At the same time, we were losing crops because of some bad weather. All of this combined to ruin our finances.

My situation could have been even worse. I know several farmers who have had to sell their farms and file for bankruptcy to settle their medical debt. In some ways, I was lucky. Our house was paid for, and while our farm was tied up in debt, we were able to make the payments.

However, contracting the West Nile virus has changed my life and my livelihood. I developed chronic fatigue syndrome, a common complication of the West Nile virus. The chronic fatigue bothers me every day to some degree. In 2006, I was forced to abandon farming because of the aches and pains and the inability to do the physical labor that was needed. The land I used to farm has been rented out and I've gotten rid of the machinery. My wife now works at a metal fabrication company in McPherson and to supplement her income, I take on odd jobs as my health will allow me to. Throughout all of this, we wouldn't have had health insurance had it not been for my wife's employment.

I still have a teenage daughter at home, so my wife and I continue to face expenses besides what we pay to care for ourselves. We thought we were being financially responsible and had planned well for the future, but my credit is shot and our savings are gone. I don't think I can ever retire.

My experience is similar to thousands of Kansans who have found themselves with more debt than they can possibly manage for situations that are not their fault. I appreciate you providing this opportunity today and hope that my story can help.

Testimony of Mary R. MacBain, MS, CPA.CITP

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present testimony today. My name is Mary Rapp MacBain. I am a CPA residing in Shawnee. I am a volunteer at the Keeler Women's Center where for almost a year I have coached women with insurmountable and confusing medical bills. The Keeler Women's Center is a ministry of the Benedictine Sisters of Atchison and is focused on empowering women in the urban core of Kansas City through education, advocacy, personal, and spiritual development.

Through my volunteer work, I have helped my fellow Kansans cope with the medical billing process. Whether employed or with what we consider adequate health insurance, most of us would agree that it is difficult to deal with the maze of the medical billing process when one incidence requires the services of numerous medical providers. For the individuals I help with low income, or poor communication or financial acuity, coping with medical bills when they are sick by organizing them and negotiating payment plans can be frustrating, overwhelmingly stressful, and leave them in a state of helplessness. For someone who is recovering, this is often impossible, so bills aren't opened, and she may discover she has been turned over to collection before given the chance to negotiate.

The Kansans I counsel at the Keeler Women's Center want to pay their medical bills, but they don't know how to begin, whom to contact, what to say, and how to provide the information the providers need to assess and develop the women's payment plan or charity. Most of these women have health insurance, but it is insufficient and leaves them with a co-payment that takes time to pay.

Through my coaching, I have been able to educate women about their options and help them to "open their bills," organize them, calculate outstanding balances, develop an income and expense statement, and to contact the patient financial services representatives to discuss their ability to pay. My service as a volunteer, which was prompted because I was in a similar situation that I resolved positively after the fact, has confirmed my feelings that there needs to be a more transparent and easily accessible process for handling medical billing prior to receiving care.

Being more transparent about the costs of medical care and readily providing vital information about payment plans, charity care, and other options prior to receiving care should be the responsibility of every provider. Every Kansan should be able to receive the medical care required from quality providers. Brochures and counseling available at admission or information beforehand through mail or via a website would help to create accessible and patient-friendly information about what is needed to negotiate a payment plan or charity. Standardized techniques, such as income and expense statement and a checklist of information required, would help Kansans communicate to the numerous providers. Currently, each provider uses a different mechanism.

The Kansans I coach want to do the responsible thing and pay their medical bills. Many need help. I hope that you will consider these fair and equitable options so that Kansans can recover from their illnesses without the added stress brought on by the current medical billing process. Thank you for allowing me to speak today.

Testimony from John Hooge

Mr. Chairman and Members of the Committee:

My name is John Hooge. I have been an attorney in Lawrence for over 30 years. I am a fourth generation native Kansan. I attended Ottawa University, the University of Kansas School of Law, and Indiana University School of Law–Indianapolis, graduating in 1977. I returned to Lawrence upon graduation from law school. Although I have handled many types of civil and criminal cases, and started out as the city prosecutor in Lawrence, I have always handled bankruptcy cases. Debtor bankruptcy has been the only thing I have handled for a number of years. I have filed thousands of bankruptcies.

To my knowledge, I am the only bankruptcy lawyer in Kansas who has a credit counselor. We try to keep people from filing bankruptcy. The bankruptcy law now also requires people to get credit counseling from designated non-profit credit counseling agencies before they can file bankruptcy. But often, the people filing bankruptcy have no other reasonable choice to deal with their debts.

Studies show that medical bills are a primary reason why people file bankruptcy. From my experience as a bankruptcy lawyer, I know this is true. There are a number of reasons why medical bills are such a problem and most of them are directly related to either people having no insurance or being underinsured.

The following are examples of what has recently caused some of my clients to file bankruptcy:

Amber – Amber is 29 years old and about to file her second bankruptcy–both due to medical bills. In 2001, at the age of 21, she obtained a job through a temp agency but the company wouldn't hire her full-time. She was hired as a **temporary employee** and stayed in that capacity for a year. The company did not provide medical insurance for temp employees. She tried to get her own insurance but it would have cost $250 a month, which she couldn't afford. She had emergency gallbladder surgery that cost her $20,000. That caused her to file her first bankruptcy.

Since that surgery and bankruptcy, Amber has intentionally worked jobs that provide medical insurance as a benefit. But in 2005, in her mid-20's, she was diagnosed with cancer. Her medical bills had primarily been covered by her insurance, until 2 years ago when she had to have a full-body scan to see if her cancer had returned. Her insurance refused to cover it as it was due to a **pre-existing condition.** She now has numerous medical bills that her insurance doesn't cover and she finds herself having to file bankruptcy again.

Brad and Renae – Brad is an auto mechanic and makes decent money. They have full insurance coverage for their entire family. But one of their three children has had great difficulties, diagnosed as bipolar–manic depressive. They had to file bankruptcy in 2005 and eventually managed to save their house from the brink of foreclosure. When they filed, they owed over $6,000 in medical bills but would have owed much more if they had not paid the medical bills instead of mortgage loan payments. They paid these medical bills to obtain the treatment their son needed. Renae tried staying home to give their son the treatment he needed but had to return to work to make more money. They constantly have to decide what medications to purchase. They can't pay for all of them.

Recently, Brad and Renae's son had to be hospitalized to get his medications corrected. Their insurance company said his 5 day stay would be paid for but after their son returned home, the insurance company decided it wouldn't cover the hospitalization. They now owe an additional $20,000 due to this hospitalization. In addition, they have now been told that the bipolar diagnosis was incorrect. Their son is actually autistic and his treatment for years has been ineffective. They are appealing the insurance company's denial of coverage for this hospitalization. Hopefully, they will win this appeal.

Charlene – Charlene lost her husband last year. She is 65 years old and disabled. She owes over $20,000 in medical bills. In Kansas, when a person cannot afford to pay their medical bills, the spouse owes such bills. This is called the doctrine of necessaries. Charlene receives $1,568 per month in social security disability income and a $438 pension for a total of $2,006 per month. She has moved in with an adult daughter and her family and pays $300 per month for rent. She couldn't pay the bills her husband left her.

Max – Max is another client in his 50's, is not filing bankruptcy, but will probably eventually have to do so. He is self-employed and had no medical insurance when he had a heart attack. He now owes the University of Kansas Medical Center $100,000 and his doctors the same amount. They saved his life and he is making payments of $100 per month to the Med Center and to the physicians' group. The hospital's attorneys demanded payment in full but reluctantly have allowed him to make the payments. At this rate, it will take him 80 years to pay these bills.

My family - I am self-employed through my law office and do provide medical insurance for my employees and myself. My wife has serious health problems that started out as an immune dysfunction problem. That caused her to receive long-term steroid medication that damaged her bones and joints. She's had 2 hip replacements, multiple surgeries to her knees, shoulder, back and hands. She's had bones removed from both hands. I can't add my wife to my own medical insurance as it would destroy my office's insurance plan. I have high risk insurance for her but it has a very high premium, a high deductible, and only pays for one-half of her prescriptions. At least I can pay for our insurance premiums and bills.

Many people cannot pay for their medical bills and insurance premiums. The difficulty people have in paying their medical bills is relative to their income. Folks with lower income obviously have a more difficult time with a smaller amount of bills.

People with medical issues and insufficient insurance have to make difficult financial decisions constantly. As we all know, many everyday expenses have increased lately. Food, housing, medical costs. Many people simply cannot pay for the medical care they need. Do they pay for all the prescriptions their doctors say they need or do without? Do they not go see the doctor when they should–not get the preventive care, which might eventually reduce their medical bills by preventing more serious problems and trips to the hospital? Do they cut back on food? Do they delay paying rent or mortgage?

Fewer employers provide medical insurance. They hire employees as temporary employees so they don't have to provide benefits. One of my clients who filed bankruptcy a few years ago was an employee of a good local business for years. But her employer never provided insurance. She asked them repeatedly to get her medical insurance. The owner of the company finally told her "that was what bankruptcy was for".

There are a number of reasons why people can't pay their medical bills with insurance:

-some employers offer no insurance
-many people who are self-employed have no insurance
-insurance is too expensive for many low paid workers to purchase on their own
-some folks have pre-existing conditions not covered by their insurance
-medical conditions are often catastrophic and even people with good insurance can't pay the remaining amounts owed