

TARNISH ON THE GOLDEN STATE

How Medical Debt Threatens Family Financial Stability

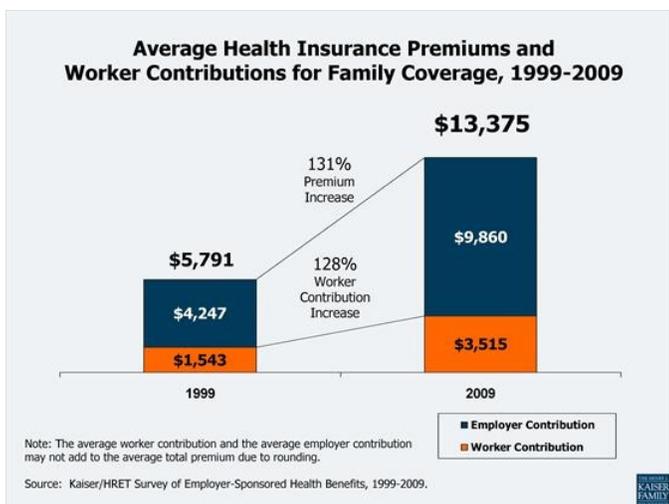
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Health Care Costs and Insurance

The burden of health care costs continues to plague the nation. Total health expenditures in the US for 2009, the most recent year for which data are available, totaled just under \$2.5 trillion.¹ In less than one decade, the health care costs for a typical family of four have doubled.²

Rising health care costs make illness and injury a serious cause of economic distress for Americans. Insurance premiums continue to climb even as policyholders are compelled to pay higher deductibles, increased co-payments, and co-insurance. Though out-of-pocket costs are typically greater for those buying coverage in the non-group or small group markets, such costs are also increasing for those with employer-based health insurance.



Nearly 50 million Americans are without any form of health insurance coverage.³ This problem has intensified during the recession since the loss of a job often also means the loss of health insurance. Nearly two million Californians lost health insurance protection during the recession, many of them experiencing a loss of private insurance coverage. As many as 8 million California residents now go without health insurance. In 2009, about one-quarter of the non-elderly California population lacked health insurance coverage for all or part of the year.⁴

Medical Debt

The lack of adequate insurance protection, combined with stagnant wages, has caused Americans to be deeply burdened by health care costs. In 2010, 73 million working-aged American adults had problems paying medical bills. One-third of working-aged American adults – 49 million people – spent more than 10 percent of their income on health insurance premiums and out-of-pocket expenses. Millions of these families lacked the financial resources to cover these costs and were left to struggle with outstanding bills. In 2010, a staggering 44 million Americans had medical bills they were paying off over time. A majority of these individuals had insurance coverage.⁵

California data reveal a similar problem for state residents. More than 2.2 million California working-age adults had medical debt in 2007 (the most recent year for which CA

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data are available). Because of the recession, it is likely that this number has increased substantially since then. Though all parts of the state experience medical debt, some areas are more deeply affected than others. Nearly one in four residents of the Northern and Sierra counties has medical debt, while one in ten residents has outstanding bills in the San Francisco Bay Area and in Los Angeles County.⁶

A considerable amount of medical debt is for relatively small amounts that nevertheless can be nagging or even devastating to those on fixed incomes or without jobs. Significant numbers of Americans and Californians are saddled with larger bills. Over half of Americans with medical debt, and over one-third of Californians, owe more than \$2,000.^{7,8}

Health Access Problems

It is well known that individuals without health insurance are more likely to delay care or forego medications than people with insurance. Medical debt is also a risk factor in terms of access to care. National studies have documented that insured individuals with medical debt have care-seeking patterns similar to the uninsured.⁹ Similarly, Californians with medical debt were more than twice as likely to delay care or to forego taking medications as those having no medical debt.¹⁰ Their reluctance about accessing care becomes more pronounced as the amount of outstanding medical debt increases.

Financial Problems

Health care costs consume family budgets and force people to make difficult choices. Medical debt is frequently a factor for Americans facing financial distress. Twenty-nine million Americans used up savings trying to pay off their medical bills. During 2010, 22 million were unable to pay for basic necessities such as food, heat or rent and 17 million took on additional credit card debt trying to pay off their medical bills.¹¹

Low and moderate-income families are hardest hit by the problem. One study found more than half of them citing medical debt as a contributing factor in their longstanding

credit card debt. They also carried higher balances on their cards and paid a higher rate of interest on them.¹²

In 2007, more than one million California residents suffered some type of financial consequence as a result of medical debt. Nearly half a million were unable to pay for basic expenses and 770,000 residents used up their savings or took out a loan in order to pay their medical bills.¹³

The Uninsured & Other Vulnerable Populations

The prevalence of medical debt is greatest among those with no health insurance. This is true both in California and nationally. Low-income populations are also more likely to have medical debt, as are women, the unemployed, and people of color.

Recent national data illustrate that women have been particularly hard hit by medical debt problems over the past five years. In 2010, an estimated 42 million working-aged women (44 percent) reported problems paying medical bills or said they were paying off medical debt over time. Two in five women with medical bill problems spent all of their savings trying to pay off these debts. Nearly one-third of the women with bill problems were unable to pay for food, heat, or rent because of their medical bills and millions more cut back on basic household expenses. Millions of women put off furthering their education or making career changes as a result of outstanding medical bills.¹⁴ Using such strategies for resolving medical debt can further jeopardize the financial well-being of woman and their families.

Those who have lost jobs are particularly vulnerable to medical billing problems and medical debt. During the recession an estimated 9 million adults ages 19 to 64 lost a job with health benefits and became uninsured. Of those, nearly three-quarters reported they had problems paying medical bills or had accumulated medical debt. They also experienced problems accessing needed health care.¹⁵

Previous studies found that African-Americans and Hispanics were more likely than white Americans to have medical billing problems or medical debt.¹⁶ Though recent racial/ethnic data on medical debt are unavailable, it is probable that African-American and Hispanic populations have seen an increase in medical debt given that they are far more likely to go without insurance during the year.

Hurting Wealth Creation

Medical bills can harm an individual's creditworthiness. Tens of millions of Americans are contacted by collection agencies for unpaid medical bills each year. Medical bills sent to collection are typically reported to credit bureaus and ultimately end up on an individual's credit report. A study published in the Federal Reserve Bulletin found that more than half of all accounts in collection are medical bills.¹⁷

Collections are considered major derogatory accounts and can significantly reduce a person's credit score, though federal legislation is being considered that would erase paid-off bills from credit reports.¹⁸ All too often, medical bills are sent to collection due to a lack of clarity. One study found that two in five patients do not have confidence that the billed amount is correct.¹⁹ Confusion, errors and lengthy insurance adjudication processes can make people cautious about whether to pay a medical bill. Unfortunately, few people understand the implications of these decisions. Even after these accounts are paid in full, the blemish can remain on a credit report for up to seven years.

Though race, ethnicity, and national origin must be excluded from credit-scoring models, credit score differences exist among various populations. For example, African-Americans, Hispanics, and residents of predominantly minority census tracts have lower credit scores than other groups. While policymakers are concerned about these differences, there has been limited research done on the potential effects of credit scoring on racial/ethnic populations since these data are not readily available.

The Federal Fair and Accurate Credit Transactions Act of 2003 (Fact Act) directs the Federal Reserve Board and the Federal Trade Commission to study how credit scoring has affected the availability and affordability of credit for those population groups protected under the Equal Credit Opportunity Act. These studies have found no definitive evidence that particular demographic groups have experienced greater changes in credit availability or affordability as a result of credit scoring.

However, these studies did find that the content of credit reports differs dramatically across various demographic groups. For example, African-Americans are less likely than other racial or ethnic groups to have a revolving or mortgage account and more likely, as shown in the table, to have a reported medical or other collection item. Hispanics are also more likely to have a reported medical or other collection account on their credit reports.

Table 1

	% with medical collections	% with other collections
White	14.7	14.5
Black	35.4	47.9
Hispanic	21.5	28.9
Asian	9.1	11.6
ALL	16.2	18.4

The study also found that the removal of collection accounts had the largest effect on African-Americans, though this effect was described as modest. While the study did not identify a clear link between medical collections and lower credit scores, such disparities across different ethnic groups warrant further examination.²⁰

Dashing American Dreams

The financial harm caused by medical debt is amplified when savings are drained and at the same time credit is ruined. This increases the cost of loans and other forms of credit. Whether they deplete savings to pay off an outstanding medical bill or pay a higher interest rate on a

loan, those with medical debt will find it much harder to accumulate any financial cushion.

After short-term savings are exhausted, Americans then tap their retirement accounts and homes trying to pay off medical bills. Medical debt has been identified as a factor in tens of thousands of home foreclosures. Six percent of the families counseled through the National Foreclosure Mitigation Counseling Program cited medical issues as the primary reason for mortgage default.²¹ This exceeds the number citing an increase in loan payment as the primary factor in the default. State-specific studies have also revealed that medical debt is a significant factor in foreclosure. A survey commissioned by the Pennsylvania Association of Realtors found that nearly half (47 percent) of residents affected by home foreclosures in the state had been hit by unexpected medical bills.²²

For some Americans, medical debt pushes them over the financial edge. National studies on personal bankruptcy have found medical debt to be a factor in more than half of all bankruptcy filings.²³

The recession provided a painful reminder of the importance of a savings cushion. Sadly, most Americans do not have easy access to cash to cover emergency expenses. A recent survey exposed the severe financial fragility of US households. When respondents were asked if they could come up with \$2,000 to cover unexpected expenses in the next month, nearly one-quarter said they would not be able

to do so and an additional one in five said that they'd do so by pawning or selling possessions.²⁴ Access to an emergency savings fund would be a far better strategy for covering unexpected medical expenses.

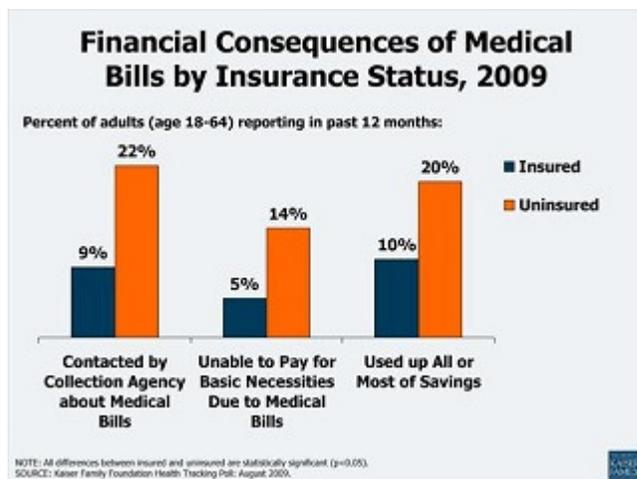
New Public Policy Opportunities to Reduce Medical Debt

Policies such as those advocated by the New America Foundation's Asset Building Program strive to encourage savings and asset building, especially among low and moderate income populations. Illness or injury, combined with inadequate health insurance protection, can interrupt efforts to improve financial security. Medical debt is one of the most significant factors that hampers wealth creation and makes obvious the link between lack of wealth and poor health.

Efforts to increase savings are assisted by having health insurance and hampered by taking on medical debt. Research conducted by asset building practitioners found that individual development account (IDA) participants with health insurance were more likely to be savers than are people without health insurance. Participants with health insurance made higher monthly deposits and saved greater amounts over the life of the IDA program. The study also found that medical debt was the most common debt held by participants. Those with medical debt made smaller deposits into their accounts and were more likely to drop out of the program.²⁵

Passage of the Affordable Care Act offers numerous new opportunities to expand insurance coverage, increase safeguards against inadequate coverage, and reduce unneeded trips to the emergency room—all key underlying causes of medical debt. Under the Act, which was passed in March 2010 and will be implemented over a number of years, insurance expansion is projected to cover nearly 32 million Americans who are now without coverage.

Over the next few years Americans can expect to see new coverage opportunities offered both through public



programs and private insurance. Insurance quality and access should improve, leaving fewer Americans with unaffordable medical expenses. Organizations working with low and moderate income people must take full advantage of the ACA's protections. Certain provisions of the ACA have particular salience for those concerned with financial opportunity and security. They include:

Medicaid and Safety Net Expansions

Roughly half of the newly-insured will be enrolled in Medicaid and the Children's Health Insurance Program (CHIP). By 2014, the Medicaid program will be expanded to cover all non-Medicare eligible individuals under the age of 65 with household incomes under 133 percent of the federal poverty level (\$14,484 for an individual and \$29,726 for a family of four in 2011 dollars). The ACA increases federal support for community health centers by creating an \$1 billion fund to support expanded operational capacity, as well as construction and renovation of clinics. This support will allow clinics to serve more Medicaid beneficiaries as well as undocumented immigrants and those who will remain uninsured, a point of special importance to California.

Expansion of public programs will help millions of Americans achieve access to care and avoid financial ruin, given the out-of-pocket cost protections that are typically associated with these programs. A recent Oregon study found that Medicaid coverage increased access to needed care while decreasing the likelihood of out-of-pocket costs, medical debt or having a medical bill sent to collection.²⁶ The study also found that Medicaid beneficiaries reported improved physical and mental health.

Creating Health Insurance Exchanges

Individuals without affordable employer-sponsored coverage will be able to purchase private insurance coverage through a health insurance exchange. This coverage will be made more affordable for those with household incomes of under four times the federal poverty level through using

premium subsidies, offering tax credits and by limiting out-of-pocket expenses.

Small businesses with up to 100 employees will be able to purchase health insurance coverage for their employees through a special small business insurance exchange. As a temporary measure, beginning in the 2010 tax year, businesses with fewer than 25 employees and average annual wages of less than \$50,000 were eligible for a tax credit if they paid a minimum of half of the cost of coverage for their employees.

In September of 2010, California became the first state to establish a health insurance exchange using the flexibility offered under the ACA. The state will create an exchange that will function as an active purchaser in the health insurance marketplace, meaning that it can potentially influence the design and availability of insurance products that are now offered to those who purchasing coverage on the individual marketplace.²⁷

Protections for those with Private Coverage

The implementation of provisions aimed at improving the quality of health insurance has already begun. In the first year after the law's passage, protections requiring that insurers spend a minimum percentage of the premium dollar on medical services or provide rebates to policyholders, as well as eliminating lifetime limits on insurance coverage, have benefited tens of millions of Americans. To protect against unwarranted insurance premium rate hikes, states will begin to review premium increases and require insurers to justify rate hikes. As a means of ensuring the maximum protection from private insurance coverage, Americans will be guaranteed the right to appeal insurance company coverage decisions to an independent third party.

An important piece of federal legislation enabled millions of Americans to maintain employer-based health insurance even though they had lost their jobs. Congress passed a provision to provide a subsidy amounting to 65% of the

monthly COBRA payment for people collecting unemployment benefits. This temporary measure enabled millions of American families to maintain health coverage, and protect their savings, at a time of great vulnerability.

Keeping Young Adults Insured

Effective September 2010, health insurers had to offer coverage to enrollees' children up to the age of 26 regardless of whether the children were students, dependents, or lived with the parent. Many insurers adopted this provision soon after the ACA was enacted. The US Department of Health and Human Services estimates that 1.2 million young adults will take advantage of this provision and sign up for coverage in 2011, and current take-up rates suggest that this projection is on track.

New Policies on Medical Debt Reporting

Moreover, there are ample policy opportunities beyond the Affordable Care Act that would mitigate problems resulting from medical debt. Of particular importance are policies related to the reporting and treatment of medical debt on credit reports. Action at both the state and federal levels could help ease spiraling financial problems that result for people with medical bills that have been sent by providers to collection agencies.

State Action

State policymakers can do a great deal to help to relieve the burden of medical debt. For example, the Massachusetts Attorney General's Office has issued community benefit guidelines for the Commonwealth's non-profit hospitals. These guidelines, though voluntary, compel hospitals to develop reasonable policies for collecting on medical debt for patients with a limited ability to pay, whether insured or uninsured.

The guidelines recommend that hospitals, and their agents, refrain from reporting patients' debt to a credit reporting agency unless specifically approved by the hospital's board of directors. If reported, the guidelines encourage hospitals

and their agents to remove these items from the patient's credit report once the debt is paid in full.

The Massachusetts guidelines discourage hospitals from charging interest on patient debt or selling patient debt unless specifically approved by the hospital's board of directors. They also discourage the practice of garnishing a patient's wages or seeking a lien on a personal residence or motor vehicle to collect patient debt unless specifically approved by the hospital's board of directors.

During 2010, 22 million were unable to pay for basic necessities such as food, heat or rent and 17 million took on additional credit card debt trying to pay off their medical bills.

Illinois has enacted a Hospital Fair Billing and Collection Practices Act. This law protects Illinois patients from unfair hospital billing and collection practices and prohibits hospitals and their collection agents from using abusive or deceptive practices during the debt collection process. It prohibits legal action against uninsured patients for uncollected hospital bills if they have demonstrated that they cannot meet their financial obligations because of insufficient income and assets. It also mandates that hospital trustees approve fair billing and collection policies.

It is interesting to note that the Illinois Department of Revenue recently denied property tax exemptions to three non-profit hospitals based on the amount of charity care reported and their billing and collection practices.²⁸ It is anticipated that more Illinois hospitals will be scrutinized for the amount of charity care provided to needy patients and also the practices used to collect on bills incurred by these patients.

Federal Action

Proposed Federal Legislation

Legislation has been introduced in the 112th Congress that would exclude medical debt that has been fully paid or settled from credit reports. H.R.2086, the Medical Debt Responsibility Act of 2011, would no longer allow the credit bureaus to penalize consumers who have paid their medical collection accounts.²⁹ The proposed legislation requires the removal from credit reports only for those medical bills that have been paid and have no balance due. At present, these accounts, even if promptly paid off after being sent to collection, remain on a credit report as derogatory accounts for up to seven years. It is estimated that 3.5 million Americans have paid-off medical collection accounts on their credit reports.³⁰

Internal Revenue Service

The Internal Revenue Service has jurisdiction over non-profit hospitals and other tax-exempt institutions. Federal law requires that these tax-exempt institutions regularly file reports to the IRS using Form 990. This form is intended to capture information on how the organizations are fulfilling their charitable purpose. In 2007, the IRS released a revised Form 990 and included Schedule H for use by non-profit hospitals to report their community benefit activities.

The Affordable Care Act added new regulations to the IRS Code regarding non-profit hospitals. The following requirements must be met in order for hospitals to retain their tax-exempt status.

1. *Financial Assistance Policy.* Each hospital must have a written financial assistance policy. The policy must include: eligibility criteria for financial assistance and whether such assistance includes free or discounted care; the basis for calculating amounts charged to patients; the method for applying for financial assistance; and measures used to publicize the policy within the community to be served by the organization. In addition, each hospital must have a written policy ensuring care of emergency conditions,

without discriminating against individuals based on their eligibility under the financial assistance policy.

2. *Limited Charges.* Each hospital must limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy to not more than the lowest amounts charged to individuals who have insurance covering such care, and must prohibit the use of gross charges.

3. *Billing and Collection.* Hospitals must not engage in extraordinary collection actions before they or their agents have made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy.

4. *Community Health Needs Assessment.* Each hospital must conduct a community health needs assessment every two years (for tax years beginning after March 23, 2012). The assessment is used to develop a strategy to address the identified community health needs.

The IRS has revised Schedule H to implement these new requirements. These provisions, and the information reported on Schedule H, represent new opportunities for those interested in addressing the medical debt problem. Community groups in California may find this information especially useful in ensuring that non-profit hospitals are developing generous charity care policies and fair billing and collection practices.

New Opportunities and Challenges for Asset Building

As these provisions suggest, increasing coverage and offering ways to lower out-of-pocket costs have significant positive implications for lowering medical debt and increasing the opportunities for Californians and Americans to increase their savings and to build financial security. This is especially true for younger and low-income Americans. The adoption of the Affordable Care Act

provides an opportunity for collaboration between those in the health policy and assets fields. The latter have expertise on the financial challenges facing low- and moderate-income Californians. Their knowledge and experience will be crucial to informing the ACA implementation process. The asset building field also has data on program clients and outcomes that could help to inform policy discussion on healthcare affordability for low- and moderate-income California families.

California also has special circumstances that make its situation more fluid than in other states. The number of California residents who stand to gain health insurance coverage under Medi-Cal alone exceeds the total number of uninsured in all but a handful of other states. But current cutbacks in the face of severe state budget deficits threaten these expansions even before they are rolled out. On the other hand, the speed with which the state has established

its health exchange under the Affordable Care Act, pending other decisions about benefit design, eligibility, and products offered, are promising developments both toward expanding coverage and reducing the likelihood of medical debt.

Conclusion

Medical debt results from inadequate health insurance and unaffordable health care costs. Fortunately, it is a problem that can be effectively addressed through federal and state policy. Successful implementation of the Affordable Care Act will be critical to the physical, mental and financial health of Californians and all Americans. California policymakers should act quickly to expand insurance coverage and take steps to alleviate credit problems for those with medical debt. Doing so would protect Californians and help them enjoy financial stability and peace of mind.

Notes

- 1 National Health Expenditures Data 2009, https://www.cms.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage
- 2 2011 Milliman Medical Index, Milliman Research Report, May 2011
<http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2011.pdf>
- 3 U.S. Bureau of the Census, “Income, Poverty, and Health Insurance Coverage in the United States: 2009,” September 2011.
- 4 Shana Alex Lavarreda, et al., “Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009,” Health Policy Research Brief, UCLA, March 2010, <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=401>
- 5 Sara Collins, et al., “Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief,” The Commonwealth Fund, March 2011.
- 6 Richard Brown, et al., “The State of Health Insurance in California: Findings from the 2007 California Health Interview Survey,” Center for Health Policy Research, UCLA, August, 2009.
- 7 Sara Collins, “Help on the Horizon.”
- 8 Richard Brown, “The State of Health Insurance in California.”
- 9 Charles Hoffman, et al., “Medical Debt and Access to Health Care,” Kaiser Commission on Medicaid and the Uninsured, September 2005.
- 10 Richard Brown, “The State of Health Insurance in California.”
- 11 Sara Collins, “Help on the Horizon.”
- 12 Jose Garcia and Mark Rukavina, “Sick and in the Red,” Demos and The Access Project; September 2010
- 13 Richard Brown, “The State of Health Insurance in California.”
- 14 Ruth Robertson and Sara Collins, “Realizing Health Reform’s Potential: Women at Risk,” The Commonwealth Fund, May 2011.
- 15 Michelle Doty, et al., “Realizing Health Reform’s Potential: When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help,” The Commonwealth Fund, August 2011.
- 16 Michelle Doty, et al., “Seeing Red: Americans Driven into Debt by Medical Bills,” The Commonwealth Fund, August 2005.
- 17 Robert Avery et al., *An Overview of Consumer Data and Credit Reporting*, Federal Reserve Bulletin, Summer 2003.
- 18 Blake Ellis, “Bill Seeks to Erase Medical Debt from Credit Reports,” CNN Money, August 1, 2011.
- 19 Intuit Health's 2011 Health Care Survey, accessed at
http://about.intuit.com/about_intuit/press_room/press_release/articles/2011/IntuitHealthSurveyAmericansWorriedAboutCostsWantGreaterAccessToPhysicians.html.
- 20 Board of Governors of the Federal Reserve System, “Report to the Congress on Credit Scoring and Its Effects on the Availability and Affordability of Credit,” August 2007.
- 21 National Foreclosure Mitigation Counseling Program Congressional Update, Activity through January 2010, NeighborWorks America; May 2010, p.41.
- 22 “Job Loss, Medical Bills Among Top Factors Contributing To Home Foreclosures In Pa,” PA Realtors Association Press Release, August 2010.
<http://www.parealtor.org/content/upload/AssetMgmt/Publications%20News%20and%20Research/Foreclosure%20Study%20Media%20Kit/Foreclosure%20survey%20press%20release%2008-04-10.doc>
- 23 David Himmelstein, et al.; “Illness And Injury As Contributors To Bankruptcy,” *Health Affairs* 25 (March/April 2006): w74-83; David Himmelstein et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *The American Journal of Medicine*, August 2009.

- 24 Annamaria Lusardi, Daniel Schneider, and Peter Tufano, “Financially Fragile Households: Evidence and Implications,” National Bureau of Economic Research, Working Paper No. 17072, May 2011.
- 25 Rachel Banov, “The Effect of Health Insurance on Savings Outcomes in Individual Development Accounts,” Center for Social Development, Washington University, Research Report, 05-29, 2005.
- 26 Amy Finkelstein et al., “The Oregon Health Insurance Experiment: Evidence From The First Year,” The Oregon Health Study Group Working Paper 17190, National Bureau Of Economic Research, July 2011.
- 27 Micah Weinberg and Leif Wellington Haase, “State-Based Coverage Solutions: The California Health Benefit Exchange,” The Commonwealth Fund, May 2011.
- 28 “Illinois Denies Tax Exemption to Chicago, Naperville Hospitals,” *Chicago Tribune*, August 16, 2011.
- 29 For full text of H.R.2086 -- Medical Debt Responsibility Act of 2011, see <http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.2086>:
- 30 Extrapolation from data included in An Overview of Consumer Data and Credit Reporting, Federal Reserve Bulletin, Summer 2003.



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