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Committee on the Judiciary
Subcommittee on Commercial and Administrative Law

"Medical Debt: Is Our Healthcare System Bankrupting Americans?"

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I am tenured member of the faculty at the University of Michigan Law School specializing in bankruptcy and commercial law and am a co-principal-investigator of the Consumer Bankruptcy Project ("CBP"), a research collaboration of ten scholars at various universities whose specialties range from sociology to health policy. Another of them, Dr. Woolhandler, is also testifying today on data she and three other members of this group published regarding the incidence of medical bankruptcies. The CBP has been supported by grants from, among other sources, the American Association of Retired Persons, the Robert Wood Johnson Foundation, and my own University of Michigan.

It would be a poor use of time to repeat Dr. Woolhandler's testimony, but I would like to supplement her comments briefly regarding the CBP's methodology. I would then like to address one of my own research lines, the marked increase in the number of elderly Americans filing for bankruptcy, especially for medical reasons. Finally, I would like to use my background as a law professor to speak about the current law and possible reform.

Methodology of the Consumer Bankruptcy Project[1]

The CBP is the first research project to compile a dataset of survey responses from a nationwide random sample of 2,314 bankruptcy filers. Indeed, our survey dataset is supplemented by analyses of court records and in-depth telephone interviews with a subset of 1,032 of the respondents. I elaborate our methodology not for self-promotion but to differentiate it from the myriad other studies gauging the incidence of medical bankruptcies. Leaving aside research projects funded by industry and other interested groups, which of course have to be treated with the appropriate level of skepticism, I want to mention two types of less helpful research. Let me be very clear: these are still valuable forms of research (indeed, worthy of public funding). They just do not offer the level of insight available in the area of medical bankruptcy that the CBP's survey approach accords.

The first type of research is court records research. This is when academics abstract information about bankruptcy filers from their public court records. Again, this can provide a good starting point; indeed, the first study of the CBP did just that back in the 1980s.[2] The problem is when an issue as complex as medical bankruptcy is investigated, court records alone provide limited nuance. Some medical debt is apparent from court records: a creditor listed as "Providence Healthcare" is most likely a medical creditor. The problem is if the creditor is listed as "Capital One," an investigator has no idea whether all, none, or some of the debt owing on this credit card is to cover medical expenses. This is where the CBP surveys can shed more light. We can ask respondents directly whether medical reasons contributed to their need to file bankruptcy. We can ask them whether they missed two or more weeks of work due to medical reasons before filing. We can ask them in telephone interviews whether they are using their credit cards to pay for medical expenses. None of these finer-grained insights are ascertainable by court records

[1] Detailed methodology is explained in Appendix I of Robert M. Lawless, Angela K. Littwin, Katherine M. Porter, John A. E. Pottow, Deborah K. Thorne & Elizabeth Warren., *Did Bankruptcy Reform Fail? An Empirical Study of Consumer Debtors*, 82 AMER. BANKR. L. J. 349 (2008).

[2] *See* TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA (Oxford Univ. Press 1989).

alone; studies that purport to offer insight on medical bankruptcies without such disaggregation are of limited utility.

The second type of research comes from public datasets, such as my own University of Michigan's well known Panel Survey of Income Dynamics ("PSID"). Again, these are useful datasets to glean information regarding general population trends, and one can access high numbers of respondents, which generally contributes to statistical power and validity. The problem with these broad-based surveys is that they lack a focus on the bankruptcy process, which has documented stigma effects that call into question respondents' credibility.[3] For example, our bankruptcy researchers ask questions of people who are already bankrupt and know that we know that. In their interviews, they ask candid questions about health and spending habits to people whose financial collapses are public. By contrast, when people were asked in the broad-based PSID whether they have ever filed bankruptcy, they responded at a fraction of what the actual bankruptcy filing rate was in the general population, suggesting they conveniently "forgot" their bankruptcies in answering these PSID surveys (this is known more formally as social desirability bias).[4]

Finally, I want to commend Dr. Woolhandler and her co-authors' conscientiousness regarding their earlier studies on medical bankruptcy. As she points out, the definition of "medical bankruptcy" could mean a number of things: it could mean someone whose medical debts exceed a certain absolute dollar amount, or certain percentage of their income. Or it could mean someone who lost income or a job, or even had to mortgage his or her home, due to medical bills. Or it could mean any combination of these. For example, in their analysis of the 2001 CBP data, one definition of medical bankruptcy Dr. Woolhandler and her co-authors chose was having in excess of $1,000 in unpaid medical bills.[5] She then used that definition in her recent research to compare apples to apples and found the troubling growth in medical bankruptcies.

But then, as do all good researchers, she responded to respectful academic criticism of her prior work. Why not try, some suggested, a more stringent definition to see if the results held or collapsed? So she did, and redefined medical bankruptcy as exceeding $5,000 in medical debts (or, as an even more sophisticated measure, debts exceeding 10% of one's gross annual income). Statisticians call this a "robustness check." The findings with even this more stringent definition changed only modestly, dropping her 69% estimate to 62%: she still finds an astounding 2/3 of bankruptcies medically originated, indicating considerable robustness. Of course, some critics will never be happy – they may ask why not redefine as medical debts exceeding $10,000, or $100,000, or $1,000,000. But they miss the point: what good researchers

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[3] *See, e.g.*, Deborah Thorne and Leon Anderson, *Managing the Stigma of Personal Bankruptcy*, 39 SOC. FOCUS 77 (2006) (using CBP 2001 data).

[4] The implausibly low 0.4% bankruptcy filing rate extrapolated from the PSID question is discussed, among other places, in Dr. Woolhandler's own paper, *see* David U. Himmelstien, Deborah Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MEDICINE 741 (2009), at text accompanying note 13.

[5] *See* David U. Himmelstein, Elizabeth Warren, Deborah K. Thorne & Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS (MILLWOOD), February 2, 2005 [web exclusive], *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1 (last visited July 27, 2009).

try to do with statistics is estimate naturally immeasurable "noumenal" realities.[6] Dr. Woolhandler should not be faulted with proffering alternative definitions of a "medical bankruptcy"; she should be applauded.

Elder Americans in Crisis

In analyzing the demographics of the rising number of consumer bankruptcy filings, the CBP finds the most rapid escalation in Americans in the over-65 demographic. In fact, the number over 55 is rising too – well beyond the growth of this age cohort in the general population.[7] In 1991, approximately 2.1% of bankruptcy filers were over 65. By 2001 that number had more than doubled to 4.5%. Our 2007 data find the number has risen again to around 7.0%. (Dropping the age threshold to 55 finds those percentages increasing from 8.2% in 1991 to 11.7% in 2001 and doubling again to 22.3% in 2007.) Thus, in analyzing the bankruptcy filings of American families over the past few years, what is most striking to us in terms of demographic findings is how elder Americans are the most rapidly growing age group – at a rate of over 100%.

Why are the elderly filing so much more now for bankruptcy? One important reason appears to be medical bankruptcy. In fact, multivariate regression analysis (a statistical technique that some scholars mistakenly believe is both necessary and sufficient to establish causation) of CBP data reveals that age is a positive and statistically significant predictor of medical bankruptcy filing. The "odds ratio" of age is 1.016 per year ($p = .0001$). This means that for each year older you are, you are 1.016 more likely to have your bankruptcy have been for a medical reason.[8] Indeed, using some of the same variables Dr. Woolhandler and colleagues report for "medical bankruptcy," I can share some of my own initial data runs on elder filers. (I should add quickly that these are not yet published findings and my statistical and research assistants will want to double check for errors, but they are the preliminary results I generated in part to help this committee consider the impact medical bankruptcies are having on the rapidly increasing cohort of elderly filers.):[9]

- Specifically identified medical problem of the debtor or spouse (39.1%) or another family member (6.8%) as a reason for filing bankruptcy.
- Specifically said medical bills were a reason for bankruptcy (32.5%).
- Lost two or more weeks of wages because of lost time from work to deal with a medical problem for themselves or a family member (11.29%).
- Mortgaged home to pay for medical bills (4.4%).

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[6] "Noumenal" is used in the Kantian sense, which is probably more metaphysical explanation than is of interest to this committee.

[7] Our CBP results on aging trends are published in Deborah Thorne, Elizabeth Warren & Teresa A. Sullivan, *The Increasing Vulnerability of Elder Americans: Evidence from the Bankruptcy Court* 3 HARV. L. & POL'Y REV. 87 (2009).

[8] The regression results are reported at Himmelstein et al., *supra* note 4 , at table 4.

[9] Sara Greene is a CBP research assistant who helped with these runs and deserves acknowledgement. "Elder" is defined as either the primary or the secondary bankruptcy petitioner being 65 or over.

- Incurred more than $5,000 or 10% of annual household income in out-of-pocket medical bills (30.2%). (25% for just the $5,000 uncovered medical bills part.)

- Total, one or more of the above criteria: 67.3%.

I am less preoccupied than others with trying to find the exact, perfect definition of a medical bankruptcy. Some would take only the first criterion – or first two criteria – as "real" medical bankruptcies.[10] Others would, mistakenly in my mind, focus solely on debt levels. (The mistake stems from the logical slip that only medical debt levels are relevant to analyzing healthcare costs. This is not so. Someone who has to reduce work due to a medical condition, resulting in an eventual bankruptcy, may very well have ended up in that situation because prohibitive health care costs dissuaded him or her from seeking earlier, timely medical intervention that could have mitigated or even eliminated the subsequent medical complication.) Still others would insist on the broadest definition possible, including gambling and family deaths as medical causes. With respect, I think this squabbling misses the forest for the trees. Even on an excessively (and overly) cautious definition of "medical bankruptcy" using only the first criterion above, 46% of elderly bankruptcy filers are directly ascribing a medical problem as a reason for their filing – a remarkably high number in its own right. Whatever the metric one prefers, it cannot be denied that the numbers are rising. Debating whether the problem has gone from bad to terrible or terrible to disastrous is all distracting noise from the broader and more important observation that things are getting worse.

I raise one final, sobering consideration on these elder filers. Most elder Americans are supposed to be covered by medical insurance: Medicare. If the health care costs in this country are driving tens of thousands of those covered by Medicare bankrupt – and doing so at an accelerating rate – surely we have serious, structural dysfunction in our health care system.

Bankruptcy Law

I am a law professor, and I teach and study bankruptcy law. One thing I can do is share my knowledge of the Bankruptcy Code for this committee. As many of you are likely aware, in 2005 transformative amendments to the Bankruptcy Code took effect with the goal of making it harder for consumer debtors to file for bankruptcy relief. Euphemistically entitled the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA"),[11] the law was, I believe, genuinely intended by many of its supporters in Congress to weed out perceived system-gamers who were using the bankruptcy laws for strategy rather than needed relief. Its selected instrument was an income-focused "means test" that drove higher income filers out of Chapter 7 bankruptcy into Chapter 13 or out of the system altogether.[12]

[10] Elder respondents citing either of the first two criteria listed above: 48.6%.

[11] Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, 119 Stat. 23 (2005).

[12] *See* 11 U.S.C. § 707(b) (2009). "The heart of this [BAPCPA] bill is the means test. It requires the bankruptcy trustee to examine the income and expenses of high income debtors and determine whether they have the ability to pay something toward their debts." 151 CONG. REC. S1779 (daily ed. Feb. 28, 2005) (remarks of Sen. Specter).

The CBP analyzed the first national random sampling of bankruptcy filers after BAPCPA to examine their incomes (as well as other financial characteristics).[13] We published our findings suggesting that BAPCPA did not appear to have weeded out high-income filers as intended but rather had a seemingly random impact: cutting the numbers of bankruptcy filers, to be sure, but not by virtue of their incomes. In academic statistics-speak, we would call this having a "non-selective" effect.

What is important about the means test that is currently part of the Bankruptcy Code is that it does not distinguish "medical debtors" or otherwise accord them any heightened protection that the average store charge-card junkie would enjoy. To elaborate this observation requires some wading into statutory language, for which I might be inclined to apologize were I not testifying before members of Congress.

The means test, operationalized in § 707(b)(ii) of the Bankruptcy Code, runs debtors through a screen of both gross and net income. Debtors with below-median gross income pass automatically (although, importantly, they still have to comply with the burdensome and expensive post-2005 filing requirements). Debtors with above-median gross income then fill out more paperwork to deduct certain permitted expenses from the monthly income (largely under IRS guidelines for delinquent taxpayers). The only relevant deduction related to medical debtors is for monthly expenses for health insurance and health savings accounts, as well as the continuation of pre-existing expenses for a family member who cannot pay his or her own expenses. That means debtors who have accumulated mounting medical bills, or who have charged up credit cards to cover living expenses while on reduced work time to fight an illness, receive no relief whatsoever from the means test. With its narrow focus on current monthly income, the means test is unable to appreciate the reality of how families struggle financially with medical hardship. I continue to do some pro bono consumer bankruptcy work, so I actually see this "in the trenches." For example, if you had an oxygen tank, and you paid a regular tank rental bill each month, the means test would probably let you deduct that. But if you racked up $10,000 in hospital bills before going home with that oxygen, the means test ignores it.

Secondly, the means test has a much-touted "exception," codified in § 707(b)(2)(B). I say "much-touted" because when BAPCPA was passed, many pointed to this "exception" as a way to help out medical debtors.[14] Here is where close statutory reading is necessary. All § 707(b)(2)(B) actually says is that if a serious medical condition adds additional expenses, those expenses may be deducted from monthly income in running the means test. Thus, § 707(b)(2)(B) is in no way an "exception" – it is just an additional deductible expense within the broader means test framework. (To be comprehensive, I should add that § 707(b)(2)(B) also allows income adjustment too, but again, all within the means test.) Again – critically – the scenario of someone who missed a month of work convalescing or who accrued substantial hospital bills would receive no help whatsoever under the § 707(b)(2)(B) "exception" that was supposed to save medical debtors by rebutting the means test's presumption of abuse.

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[13] *See* Lawless *et al.*, *supra* note 1.

[14] *Cf.* 151 CONG. REC. S1856 (daily ed. Mar. 1, 2005) (statement of Sen. Grassley) ("So that I am crystal clear, people who do not have the ability to repay their debts can still use the bankruptcy system as they would have before . . . .").

My skepticism with § 707(b)(2)(B)'s capacity to mitigate bankruptcy for medical debtors led me to analyze our CBP files for debtors who successfully employed its exception. That is, I sought to determine how many debtors flunked the means test but were able nevertheless to avail themselves to this exception (which also applies to armed service members) to evade the consequences of a means test flunking. The results were striking. Of the 1,823 chapter 7 debtors I looked at in our dataset, exactly four (0.2%) even filled out the part of the bankruptcy petition where one would try to claim special circumstances.[15]

Proposals

As a bankruptcy professor, I have the distinction of simply reporting bad news about bankruptcy and medical costs; I can evade the much tougher task of designing solutions. That hard work falls to Congress, and I commend their efforts at digging deep for data to shape their proposals. Naturally, as a bankruptcy law expert, I gravitate towards the Bankruptcy Code. Many if not most experts suggest abolishing the means test as what can be most charitably described as a well intentioned failure.[16] I join them, not only because I have increasing faith that U.S. trustees and bankruptcy judges can likely screen abuse adequately without a statutory straightjacket, but also because I have now seen the data of non-selective effects and I worry that the means test is in a sense backfiring: drawing many needy Americans away from financial relief in bankruptcy they require. The cost of this means test system is huge in terms of deluging debtors and court clerks with compulsory (and unnecessary) paperwork, a cost that seems especially poignant for debtors who went bankrupt solely for medical reasons.

But I also believe that incremental reform works. If we are not ready to confess error on the means test and scrap it altogether, then we could at least exempt medical debtors – the least blameworthy debtors needing relief – from its operation. Proposed H.R. 901 clearly takes a step in the right direction in trying just such an approach, and even takes a pretty workable stab at defining a "medical" bankrupt.[17] Some might say, "Why provide means test relief for medical bankrupts but not other worthy, faultless debtors?" I join Voltaire in cautioning the best becoming the enemy of the good.

The broader question, of course, taking off my bankruptcy hat, is what reforms "upstream" could help these people before they even go bankrupt? Here I draw attention to a recent study suggesting that at least 32-49% of home-losers ascribed their mortgage foreclosures to a medical cause (without even necessarily filing for bankruptcy).[18] That question I defer to Congress. It

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[15] I would be happy to provide methodological elaboration to any interested future researcher by email: pottow@umich.edu.

[16] *Cf.* Letter from Bankruptcy and Commercial Professors to Senators Spector and Leahy (Feb. 16, 2005), *available at* http://www.abiworld.org/pdfs/LawProfsLetter.pdf (imploring Congress to consider predicted costs and inefficacies of the means test and BAPCPA).

[17] *See* Medical Bankruptcy Fairness Act, H.R. 901, 111th Cong., (2009), § 2 (defining "medically distressed debtor").

[18] *See* Christopher Traver Robertson, Richard Egelhof & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65 (2009).

would appear given how fast the ranks of the bankrupt are increasing with medical debtors that something desperately needs to be done. Whether that is more health insurance, better coverage in Medicare, or a single-payer-style system, I leave to those more expert – and more elected – than I. Again, I am just the bearer of bad news regarding the increasing incidence of medically related bankruptcy filings and its special impact on elderly Americans.

If you'll indulge me, I would like to close with a quick personal anecdote. About twenty years ago when I first came to the United State as a college student from Canada, where we have universal healthcare, I was hit by a car biking to class. I was taken to hospital in an ambulance to be treated for a separated shoulder (the bike was crushed beyond repair and became urban art in our dormitory). As I was lying on the stretcher in a neck brace in the triage room, the first question I was asked – the <u>first</u> – was how I would be paying for my medical care. This was my introduction to the American healthcare system. Surely this is no way for it to run.