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WORKING FAMILIES IN FINANCIAL CRISIS: MEDICAL DEBT AND BANKRUPTCY

HEARING

BEFORE THE

SUBCOMMITTEE ON
COMMERCIAL AND ADMINISTRATIVE LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

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CONTENTS

JULY 17, 2007

Page

OPENING STATEMENT

The Honorable Linda T. Sánchez, a Representative in Congress from the State of California, and Chairwoman, Subcommittee on Commercial and Administrative Law 3
The Honorable Chris Cannon, a Representative in Congress from the State of Utah, and Ranking Member, Subcommittee on Commercial and Administrative Law 4
The Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Chairman, Committee on the Judiciary, and Member, Subcommittee on Commercial and Administrative Law 6

WITNESSES

Ms. Donna S. Smith, Health Care Activist, Aurora, CO
Oral Testimony 12
Prepared Statement 15
Mr. Todd J. Zywicki, George Mason University School of Law, Arlington, VA
Oral Testimony 20
Prepared Statement 22
Mr. Clifford J. White, III, Director, Executive Office for U.S. Trustees, U.S. Department of Justice, Washington, DC
Oral Testimony 41
Prepared Statement 43
Ms. Elizabeth Warren, Harvard Law School, Cambridge, MA
Oral Testimony 50
Prepared Statement 53
Mr. Mark Rukavina, Executive Director, The Access Project, Boston, MA
Oral Testimony 71
Prepared Statement 73
Mr. David U. Himmelstein, Harvard Medical School, Cambridge, MA
Oral Testimony 83
Prepared Statement 86

LETTERS, STATEMENTS, ETC., SUBMITTED FOR THE HEARING

Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Chairman, Committee on the Judiciary, and Member, Subcommittee on Commercial and Administrative Law 8
Prepared Statement of the Honorable Steve Cohen, a Representative in Congress from the State of Tennessee, and Member, Subcommittee on Commercial and Administative Law 10

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Additional Information Submitted by Mark Rukavina, Executive Director, The Access Project, Boston, MA 131

Page

Bankruptcy Forms Submitted by the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Chairman, Committee on the Judiciary, and Member, Subcommittee on Commercial and Administrative Property 197
Post-Hearing Questions Submitted to the Witnesses 240
Answers to Post-Hearing Questions from Todd J. Zywicki, George Mason University School of Law, Arlington, VA 248
Answers to Post-Hearing Questions from Clifford J. White, III, Director, Executive Office for U.S. Trustees, U.S. Department of Justice, Washington, DC 251
Answers to Post-Hearing Questions from Elizabeth Warren, Harvard Law School, Cambridge, MA 255
Answers to Post-Hearing Questions from Mark Rukavina, Executive Director, The Access Project, Boston, MA 265
Answers to Post-Hearing Questions from David U. Himmelstein, Harvard Medical School, Cambridge, MA 275

WORKING FAMILIES IN FINANCIAL CRISIS: MEDICAL DEBT AND BANKRUPTCY

TUESDAY, JULY 17, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMERCIAL
AND ADMINISTRATIVE LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:15 p.m., in Room 2141, Rayburn House Office Building, the Honorable Linda Sánchez (Chairwoman of the Subcommittee) presiding.

Present: Representatives Sánchez, Conyers, Johnson, Lofgren, Delahunt, Watt, Cohen, Cannon, Jordan, and Franks.

Staff present: Susan Jensen-Lachmann, Majority Counsel; Daniel Flores, Minority Counsel; and Adam Russell, Professional Staff Member.

Ms. SÁNCHEZ. The Subcommittee on Commercial and Administrative Law will come to order.

Without objection, the Chair is authorized to declare a recess at any point.

Before we begin with today's agenda, we have some unfinished business from our hearing, last Thursday, regarding Ms. Harriet Miers. Having reviewed the pertinent part of the transcript from the hearing, reviewed relevant precedents, and consulted with the parliamentarian, the Chair is prepared to reconsider her ruling regarding the words of the gentleman from North Carolina.

Without objection, that hearing is hereby reconvened, and the Chair's ruling is vacated.

I recognize the gentleman from Utah, our distinguished Ranking Member, to identify the words he believed to be unparliamentary. Mr. Cannon?

Mr. CANNON. Thank you, Madam Chair.

The Committee has provided a transcript. I think the easiest way to identify the words is by identifying the lines in the transcript, which I think should be sufficient for our purposes.

So on page 51 of the Committee transcript, beginning with line 1205 and continuing down through line 1224, and then on the following page, beginning with line 1239 and continuing through line 1242.

Mr. WATT. Madam Chair?

Ms. SÁNCHEZ. I would recognize the gentleman from North Carolina and ask if he wishes to ask unanimous consent to withdraw those words.

Mr. WATT. I do ask unanimous consent to withdraw the words identified by Mr. Cannon.

Mr. CANNON. Madam Chair, resuming the right to object.

Mr. WATT. He has shown me the words, and I have reviewed them. So I ask unanimous consent to withdraw them.

Ms. SÁNCHEZ. Thank you. The gentleman asks unanimous consent.

The gentleman from Utah is recognized under his reservations.

Mr. CANNON. Thank you, Madam Chair.

First of all, I would like to thank you and also the staff for doing a remarkably thoughtful job on resolving this concern.

Let me say that I really appreciate the passion of Mr. Watt. He has been a dear friend. We have worked together on many, many issues, including protecting voice-over protocol or voice on Net from regulation. I think he is actually the father of the fact that we can do Internet telephony without regulation and that through the Committee or his Ranking Member he had the courage to bring an amendment. And so, I reluctantly objected to his words the other day and appreciate him as a person.

This is an issue that has encouraged a great deal of passion. And I understand that. I just hope as we continue that the majority will consider the evidence and proceed with calm rationality, which I personally expect will mean that we move on to other issues relatively soon.

Thank you, Madam Chair. And I withdraw my reservation.

Mr. WATT. Mr. Cannon?

Mr. CANNON. I yield to the gentleman.

Mr. WATT. Will the gentleman yield for a second?

Ms. SÁNCHEZ. The gentleman yields time.

Mr. CANNON. I would be pleased to yield.

Mr. WATT. I just wanted to say a few words, if it is okay with the gentleman.

Mr. CANNON. Certainly.

Mr. WATT. First of all, I appreciate the spirit in which the gentleman has proceeded. And I appreciate the spirit in which the Chair of the Committee has proceeded. I operated in a legal framework for 22 years before I came to this Committee. And there are certain rules that applied there.

And I have been in this context for 15 years. And there are certain rules of process that apply here. Once I became aware that the parliamentarian had decided that—had ruled or found that the words I used were unparliamentary, I certainly didn't hesitate to seek to withdraw those words.

There is one by-product of this that I wanted to comment on and actually apologize for because some people have interpreted what I said, although having reviewed the words that I said, I never said what people have interpreted as.

Some people have interpreted what I said to be that I said that the President of the United States was a liar. I want to make it clear that that is not in the transcript, first of all.

And if it were in the transcript or to the extent that people interpreted what I had to say as saying that the President is a liar, I want to make sure I apologize to the President for that because the President is a personal friend of mine. And I don't want anybody

left with the impression that I think the President in general terms is a liar.

So I appreciate the gentleman yielding. And I will yield back to the gentleman.

Mr. CANNON. I thank the gentleman.

And let me point out that having known the gentleman for years and having had many, many courtesies on this Committee extended to me by the gentleman, I want to reaffirm his words that his intentions were not, as has been characterized in some circumstances.

And, Madam Chair, I would also like to make just one other point. That is that a Member of the full Committee who is not a Member of this panel, Dan Lungren, got engaged in this issue early and with some intensity. And I think his intentions were to maintain the integrity of this body.

I think he acted honorably. And I just want it to be clear. There was an article in the newspaper that suggested I did things that he actually did. And those are thoughtful things. And I thought he ought to be credited with his position.

The fact is this is a complicated environment that we live in. The rules are complicated. And unparliamentary speech differs from one person to another. And I appreciate, again, the very gentle way you have handled this issue and would yield back the balance of my time.

Ms. SÁNCHEZ. I thank the gentleman.

And I thank the gentleman from North Carolina also for his thoughtful remarks.

Hearing no objection, the words of the gentleman from North Carolina that the gentleman from Utah has identified are withdrawn.

And, without objection, those words are struck from the transcript and the record.

The Chair would remind all our Members that as we debate the important and sensitive issues that come before this Subcommittee we must all take care not to misdirect the strong feelings that these issues can bring about toward our House and Senate colleagues or toward officials in the executive branch. I thank the Members for their time and their patience.

And with that, the continuation of the Subcommittee hearing on Commercial Administrative Law from last week is adjourned. And we will now move on to today's hearing.

Pursuant to notice, this hearing of the Committee on the Judiciary, Subcommittee on Commercial Administrative Law will now come to order. I will now recognize myself for a short statement.

Today's hearing will focus on one of the most critical challenges facing hard-working American families, namely the financial consequences of medical debt and how it all too often leads to bankruptcy. Although our Nation is among the wealthiest in the world, the United States is one of the few industrialized countries that do not provide health care for all of its citizens, unlike most other industrialized nations.

Medicare and Medicaid cover only the elderly and indigent. Everyone else is responsible for finding their own insurance, the cost of which has skyrocketed in recent years.

Sadly, many American families cannot afford to pay for their health insurance. Some simply earn too much money to qualify for public health insurance but earn too little to afford private insurance coverage. They are effectively caught in a catch-22, putting many at risk of financial ruin.

As a result, many Americans are going without insurance. In 2005, for example, approximately 45 million or 15 percent of Americans had no health insurance. Even the insured face possible economic disaster. Excessive premiums and deductibles, low coverage caps, and uninsured medical conditions are just some of the reasons why families that have health insurance risk financial ruin should somebody get sick.

How is this crisis treating American families? Well, not very well, I think. Studies show that many are skipping recommended treatments, not filling critical drug prescriptions, postponing doctor appointments, and cutting back on other essentials like food.

We know, particularly based on this Subcommittee's last two bankruptcy hearings, that Americans file for bankruptcy relief for a vast variety of reasons. We learned, for example, that when a major airline shirks its pension responsibilities and cuts wages, the employees and retirees face possible financial ruin.

This past May, we learned how the sub-prime mortgage industry is pushing more and more American home owners into bankruptcy. Today we will hear about a watershed study examining the role of illness and other medical factors contributing to bankruptcy. One of the shocking findings of this study is that nearly 50 percent of consumer debtors have had a major illness or health problem that propelled them into bankruptcy.

I would be remiss if I did not recognize the leadership of Chairman Conyers in drawing attention to this important issue and thank him for his efforts to bring about legislative change. It is my sincere hope that today's hearing will help us better understand the extremely serious consequences of medical debt and serve to galvanize us to work toward finding solutions.

To help us learn more about this important issue, we have six witnesses with us this afternoon. We are pleased to have Professor Elizabeth Warren, Leo Gottlieb professor of law at Harvard Law School; Ms. Donna Smith, health care activist; Dr. David Himmelstein, associate professor of medicine at Harvard Medical School; Mr. Clifford White, director of the Executive Office for U.S. Trustees; Professor Todd Zywicki, George Mason University School of Law; and Mr. Mark Rukavina, executive director of the Access Project.

I look forward to hearing today's testimony.

And at this time, I would like to recognize my colleague, Mr. Cannon, the distinguished Ranking Member of the Subcommittee, for his opening remarks.

Mr. CANNON. Thank you, Madam Chair.

I would like to extend a warm welcome to all of our witnesses and appreciate your being here today. We also have many people in the audience that have deep concerns about these issues. And I talked with some of them a little earlier. And we hope that some of their questions will be answered here today as well.

The question of whether the medical debt is causing, pardon me, many of the bankruptcies in the country is one that has been stirring since we passed the Bankruptcy Abuse Prevention and Consumer Protection Act in 2005. At that time, Professors Warren and Himmelstein published results of their study on this issue.

According to them, up to 54.5 percent of personal bankruptcies were caused by medical issues. But those alleged results have been hotly debated since publication. For example, Professor Dranove of the Kellogg School of Management at Northwestern University along with his co-author, Michael Millenson has argued that the Warren and Himmelstein study failed to demonstrate a causal relationship between medical spending and anything even approaching half of bankruptcies.

By Dranove's and Millenson's analysis, the study's data does show a causal link to medical expenses in only 17 percent of personal bankruptcies. They further suggest that even in that 17 percent of cases, the study had not established that medical debt was the most important cause of bankruptcy.

Dranove and Millenson also highlighted that the Warren and Himmelstein's preferred solution, that is, national health insurance, was actually unlikely to quell any crisis in medical debt bankruptcy. Other academics, including Professor Zywicki of George Mason University School of Law and Professor Heriot of the University of San Diego School of Law also questioned the positions of Professors Warren and Himmelstein.

I look forward to hearing more about this debate from Professors Warren and Himmelstein and Zywicki. I also look forward to hearing from the executive office of the United States Trustees. To my knowledge, the executive office has not directly criticized the Warren or Himmelstein study, but the executive office does have data of its own based on its review of official bankruptcy numbers.

I look forward to hearing about that data and whether the executive office believes the bankruptcy reform law is working for debtors with medical debt. I hope that it suggests that the BAPCPA is working, given the flexibility we left in the bankruptcy code for courts to take into account special circumstances such as medical conditions.

I have to admit I am skeptical of figures claimed by Professors Warren and Himmelstein, and I doubt that the information we hear today will definitively resolve the debate. But this is a very important issue to me and to America.

I would like to understand better the degree to which bankruptcy code may or may not be adequately serving the families and individuals beset by medical debt, which is an absolutely clear problem, whether it is 17 percent or less or 50 percent or more. The fact is that medical debt is a significant problem in America.

This is not, I don't think, the environment to deal with national health care. Although I understand there is some strongly held opinions on that issue. Rather, this is a place where we need to look at the bankruptcy act and see what can be adjusted or done to accommodate the needs of Americans, whatever the percentage of causality is. And certainly, health care is a significant issue.

I might just say that in America on the broader issue rather than the narrow issue of bankruptcy that in America we are under-

going a most amazing process of transformation in the medical industry, something akin to what happened in the telecommunications industry a few years ago.

And when we join that broader debate about national health care, we need to be thinking about not just what is hurting families or what families can afford, but rather where we are going with medical care and with innovation in medicine, which will profoundly change—it has profoundly changed over the last couple of years and will continue to profoundly change everything about the way we practice medicine, how we find the cures and how we get cures to people in America and throughout the world.

And with that, Madam Chair, I yield back.

Ms. SÁNCHEZ. I thank the gentleman for his statement.

I now would like to recognize Mr. Conyers, the distinguished Member of the Subcommittee and the Chairman of the Committee on the Judiciary for his opening statement.

Chairman CONYERS. Thank you, Madam Chairperson and the Ranking Member.

And Trent Franks is with us, as well as Zoe Lofgren, Bill Delahunt, Mel Watt, Steve Cohen. And sitting silently with us is Dr. Steve Kagen from Wisconsin, whose interest in this subject matter has brought us here.

Members of the Committee and to our distinguished panelists and those of you who have come in to witness this hearing, it is really very difficult to separate the health care crisis in this country from the particular subject matter of medical bankruptcy because they are very much tied together. Because we start off with something that I got from Paul Farmer, a doctor and anthropologist whose book, "Pathologies of Power," has just come to my attention.

And what he suggests is that there is a violence more than guns and personal physical. There is a thing called structural violence. That is that you are in a system where things are so bad that the statistics and the outcome are going to be quite bad as well. And you can't get out of it. The odds are very strong that it won't change much, except for a very brave few.

I mean, you think of a few people, Oprah Winfrey. I mean, she was against the odds and succeeded. And there are other examples. The former owner of BET comes to my mind.

But mostly, you are trapped in where you find yourself. And so that the bad statistics on health care, longevity, birth, death at birth, the birth rate. All these things come in on you.

And what happens is that I am beginning to take the attitude that medical bankruptcy is one of the consequences in America, not just of being poor because—as Michael Moore established and Donna Smith can tell us more about that—the people he was talking with were people of middle-income level who had health insurance. And so, we are beginning, or at least I am beginning, to look at this from a little bit different view.

Health care should be a human right for everybody certainly in this country, the wealthiest in recorded history. And yet because the way the system is set up, a broken health care delivery system, bankruptcy, not only which tears up families and creates stress and suffering, but then we begin to find that there are a lot of peo-

ple too courageous that don't go into bankruptcy and then they experience another setback of suffering.

And so, we have, for example, in Michigan we have people now being hit by health care experiences that could have never been anticipated. They were working at one of the big three automobile companies. They had health care.

As a matter of fact, I used to have people tell me that H.R. 676, Universal Health Care, is great, except I am with UAW and Ford, so, I mean, quite frankly, we got a pretty good deal. Well, they are not saying that any more.

As a matter of fact, their unions are endorsing the measure because the name of the game is when you go into—you start negotiating—and where did they ever get these contracts where—have you ever entered into a contract where after a year or so you come back to the person that you made the agreement with and say, "Well, that contract is off, my friend. We have got a—we have got a—things went bad, very bad this year. Our bottom line is hemorrhaging. And so, you have got to rewrite that contract"? Why, you would be laughed at.

And yet, our automobile companies in Michigan are doing that to our workers saying, "If you don't, we will go before a bankruptcy judge," Mr. White, "and we will end up giving—he will end up giving you a much worse situation, a worse deal than we would give you. We will have then cut your health care benefits, your pension benefit, the whole works, plus you will be out of a job to boot because we are planning to relocate somewhere else and not have to worry about the United Automobile Workers."

And so, I am looking at bankruptcy from that light. And I look forward to hearing from the witnesses because, as my friend said, this is the first hearing on that subject. And we are looking at how bankruptcy affects people and also how not going into bankruptcy also has a harmful effect on people.

And I just close with this example here. Whenever the companies start shutting down and closing up and threatening bankruptcy, why is it that the executives always get a bonus? I mean, it is puzzling. Here is United Airlines. The chief executive received compensation worth $39.7 million in 2006 just after the airlines emerged from 3 years of Chapter 11 bankruptcy protection, which during the course of the bankruptcy they terminated the pensions of 120,000 workers, shifted $5 billion in pension obligation to the pension trust fund, BPGC, resulting in one of the largest pension defaults in the history of the United States.

These inequities and unfairnesses aren't because somebody got sick. These unfairnesses exist because the system we have to deal with people getting sick needs to be examined much more closely than it ever has in Congress. And I think we can do a lot about it, particularly in the Judiciary Committee.

And so, I thank you for holding these hearings, Chairwoman Sánchez.

[The prepared statement of Mr. Conyers follows:]

PREPARED STATEMENT OF THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN, CHAIRMAN, COMMITTEE ON THE JUDICIARY, AND MEMBER, SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW

America's health care system is on life support. It is a broken system that is pushing millions of hardworking families into bankruptcy.

Here are just a few distressing statistics:

- *48 million Americans* lack health insurance;
- *5 million Americans* filed bankruptcy since 2000 as the result of serious medical problems;
- *80 million more Americans* facing overwhelming medical debt could have filed for bankruptcy, but did not out of sense of pride or for other reasons; and
- an estimated *58 million Americans* are at risk of incurring medical bills they may not be able to afford. This includes *17.6 million adults* with private health insurance.

While we in the United States pride ourselves as representing the "First World," sadly our health system equals that in certain Third World nations. To quote Amartya Sen:

> The situation does, of course, vary from region to region, and from one group to another. But unnecessary suffering, debilitation, and death from preventable or controllable illness characterize every country and every society, to varying extends. As we would expect, the poor countries in Africa or Asia or Latin America provide crudely obvious illustrations of severe deprivation, but the phenomenon is present even in the richest countries. For example, African Americans in some of the most prosperous U.S. cities (such as New York, Washington, or San Francisco) have a lower life expectancy at birth than do most people in immensely poor China or even India. Indeed, location alone may not enhance one's overall longevity.

Unfortunately, those in our society who are the most vulnerable are also among those who are suffering the most as a result of our health care system. As Paul Farmer observes, "The correlation between poverty, inequality, and increased morbidity and mortality is massive." This helps explain why death rates in parts of Harlem among certain age groups rival those in Bangladesh. In both places, according to Dr. Farmer, the leading causes of death in young adults are infections and violence.

Disparities based on race are particularly evident in our Nation's health care system. The infant mortality rate for African American infants, for example, continues to be unacceptably high. African American infants were 2.6 times more likely to die in the City of Detroit than a white infant in the state of Michigan, according to a 2005 report by the Detroit Department of Health and Wellness Promotion and the Wayne County Public Health Department.

According to these agencies, the infant mortality rate that same year for black babies was 18.1. Translated into real life terms, this means that *202 African American babies never saw their first birthday.* Wayne County black infants died at rates more than twice that of white infants, according to these agencies.

Tragically, this drastic difference in the death rate of African American babies is also a national trend and a significant health disparity that demands action. The health care system in our Nation is simply stacked against poor people of color.

As today's hearing will show, our Nation's current health care system is literally bankrupting hardworking American families with medical problems, including many who already do have insurance.

Keep in mind that bankruptcy is no panacea either, especially in light of the 2005 amendments to the Bankruptcy Code. These amendments force debtors to go through and pay for usually meaningless credit counseling, to file excessive documentation justifying their finances, and to complete onerous forms.

But, worst of all, is the burdensome means test by which debtors have to essentially prove that they are eligible for bankruptcy relief. One means test form alone requires a debtor to answer *57 questions* about his or her financial circumstances.

Certainly, Americans are gravely concerned about our Nation's health care system. A recent Gallup Survey reported that roughly half of all respondents said that they were worried about paying medical costs if they become seriously ill or have an accident.

We should all be concerned about overwhelming medical debt. It is not just a problem that afflicts the uninsured.

Many families who have insurance are still driven into bankruptcy by inadequate coverage, combined with rising deductibles, co-pays and premiums. The problem is

compounded when industries—such as the automobile manufacturers in my home state—lay off thousands of their employees, trim or cut the health benefits of their retirees, and force others to accept reduced medical insurance benefits. It's estimated that total job losses in the automobile industry since 2000 is about *250,000 jobs.*

At the same time as hundreds of thousands of Americans are losing their jobs, the top executives almost always get bonuses. Here's just one example. The chief executive officer of UAL Corporation, the parent of United Airlines, received compensation worth $39.7 million in 2006, just after UAL emerged from three years of Chapter 11 bankruptcy protection. During the course of its bankruptcy, however, UAL terminated pensions for 120,000 workers and shifted $5 billion in pension obligations to the PBGC, resulting in one of the largest pension defaults in the history of the United States, according to the Associated Press. These inequities are astounding.

Then, to make matters worse, families—already severely traumatized by their health problems—are pushed by our Nation's health care system into financial distress. In addition to dealing with their health concerns, they must also fend off harassing calls from debt collectors and struggle just to make ends meet. The emotional burden of serious medical debt cannot be understated.

Sadly, these families often become prey for predatory lenders, which only exacerbates their financial distress. Their damaged credit ratings cause them to have to pay higher interest rates when they refinance their mortgages or obtain loans. Surely, we can see how such circumstances drive American families further into an economic downward spiral into bankruptcy.

Then, the need to pay medical debt forces many families to forego other necessary expenditures, such as required medical procedures, prescription drugs, and even food. Americans should not be required to choose between their health care and food.

Indeed, everyone suffers when Americans, even those with full insurance, cannot pay their medical debt. Hospitals and other medical service providers must pass along the cost of bad debt to those who can pay, resulting in higher prices being charged for goods and services. This is a crisis that touches everyone.

In the recent movie *SiCKO,* filmmaker Michael Moore brings the medical debt crisis to life by sharing real stories of Americans who become bankrupt as the result of unpaid medical bills. His film makes the tragic human consequences of our broken health care system impossible to ignore.

I am pleased to welcome Donna Smith, who shared her story of sickness and financial ruin in that movie. Thank you, Donna, for turning the pain of your family's crisis into a galvanizing force for fundamental reform so that no other family will have to go through what you did.

Regrettably, this Administration has done little, if anything, in response. My bill, H.R. 676, the "United States National Health Insurance Act," would go a long way toward resolving this national crisis. It would establish a program giving Americans free health care coverage for all medically necessary procedures as well as for primary care and prevention, prescription drugs, emergency care, and mental health services.

H.R. 676 would create a single payer national health insurance program in America by expanding and improving Medicare. Nobody in America would ever receive a medical bill, and therefore, no American would ever have medical debt or have to declare bankruptcy because they got sick. No American would ever be turned away from a hospital, dentist, pharmacy, or a doctor's office because they had unpaid medical debt.

Remember that medical debt and medical bankruptcy are uniquely American phenomena that are a byproduct of our for-profit employer based health care system. Medical debt and bankruptcy are simply non-existent in the rest of the industrialized world.

As we begin deliberations in Congress about how to provide health care to all Americans, we must ensure that we do not create a universal health insurance program that simply expands the current flawed system, in which medical debt and bankruptcies are the inevitable outcome of a patchwork of unaffordable, non-comprehensive coverage. If we just expand this broken system, it is logical to conclude that millions more Americans could be subject to medical bankruptcy or ruined credit due to medical debt. We certainly do not want to go down that road.

H.R. 676 is an important first step in helping to resolve the undeniable health care crisis in our Nation, but it is not the only step.

Today, as Chairman of the Judiciary Committee, I have issued a request to the Government Accountability Office to help us answer the following critical questions:

- How many Americans each year go bankrupt due to unpaid medical debt, and how many had insurance at time bankruptcy was declared?
- How many Americans each year have medical debt placed on their credit score?
- How much do hospitals and physician offices spend each year to pay for debt collection agencies to contact delinquent patient accounts for payment?
- How many Americans each year are denied a mortgage, or denied follow up medical care as the result of medical debt?

As policymakers, we need answers to these questions so that we can we address the core problems in an efficient and meaningful way.

My other goal is to right the many wrongs inflicted by the 2005 Amendments to the Bankruptcy Code. Individuals with serious medical conditions should not be forced to take credit counseling when all the credit counseling in the world will not make one iota of difference in their financial lives. Individuals with serious medical conditions should not have to file reams of unnecessary paperwork to prove their eligibility for relief. For 25 years since the enactment of the Bankruptcy Code, the system worked perfectly fine without these requirements.

Most importantly, I plan to devise a way to exempt these individuals from the onerous means test requirements that plainly are designed to catch the unwary, but unfortunate debtor. Obtaining bankruptcy relief should not be more completed than filing a tax return, but regrettably it is and we need to fix this problem.

Yet another proposal that I intend to discuss with my good friends and colleagues on the Financial Services Committee—Barney Frank and Maxine Waters—is one that would except medical debt from credit reports.

Our goal as lawmakers should be to once and for all end the medical debt crisis through common sense and pragmatic policies so no patient in this country will ever suffer financial consequences for getting sick.

I very much look forward to hearing form our distinguished witnesses today. Let's get to the bottom of the medical debt crisis and come up with concrete public policy options that will protect the American people from the powerful economic and financial forces that are causing millions to needlessly suffer financial hardships just because they got sick.

No American should have to suffer the indignity of being evicted, not being able to buy groceries, or having to delay needed medical care because of medical debt. I think we can all agree that it is wrong, immoral, and un-American to allow theses conditions to continue in the wealthiest nation in the world.

Ms. SÁNCHEZ. I thank the gentleman for his statement.

Without objection, other Members' opening statements will be included in the record.

[The prepared statement of Mr. Cohen follows:]

PREPARED STATEMENT OF THE HONORABLE STEVE COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE, AND MEMBER, SUBCOMMITTEE ON COMMERCIAL AND ADMINISTATIVE LAW

It is a national shame that millions of Americans are being forced into personal bankruptcy because of illness combined with either a lack of health insurance or insufficient health insurance coverage. In a 2005 study by Professor Elizabeth Warren and Dr. David Himmelstein, both of whom will be testifying before us today, 46.2 percent of consumer bankruptcy debtors filed for major medical reasons. Prior to entering bankruptcy, many of these debtors had no health insurance, and many were forced to forgo other life essentials, including food, telephone service, needed doctor and dentist visits, and prescription drugs, because of their medical debt.

The fact that the cost of health care could be so high as to force someone to choose between medical care and eating is unacceptable in any civilized society, but especially so in the wealthiest nation on earth. That is why I am a cosponsor of H.R. 676, the United States National Health Insurance Act, which would create a universal health insurance program. Contrary to the claims of critics, this is not "socialized medicine." Rather, it is our fulfillment of a basic obligation to each other as Americans to ensure that no one in our society is denied the health care they need because they are poor or in difficult financial circumstances. I hope today's hearing will highlight the need for universal health care and the consequences of failing to act.

Ms. SÁNCHEZ. And, without objection, the Chair will be authorized to declare a recess of the hearing at any point.

I am now pleased to introduce the witnesses on our panel for today's hearing. Our first witness is Ms. Donna Smith, a health care activist who has tirelessly campaigned for a universal health care system. Ms. Smith resides in Aurora, Colorado.

Our second witness—you guys changed your order on me—is Professor Todd Zywicki. Professor Zywicki teaches in the areas of bankruptcy and contracts at George Mason University School of Law. Professor Zywicki was a visiting professor of law at the Georgetown Law Center for the 2004-2005 academic year. And in 2003, he served as director of the office of policy planning at the Federal Trade Commission.

Our third witness is Clifford White, director of the Executive Office for U.S. Trustees. Mr. White has previously served as an assistant United States trustee and a deputy assistant attorney general at the Department of Justice and as assistant general counsel at the U.S. Office of Personnel Management. Mr. White was recognized with a presidential rank award for meritorious executive in 2006.

Our fourth witness is Professor Elizabeth Warren. Professor Warren joined the faculty of Harvard Law School in 1992 and became the Leo Gottlieb professor of law in 1995. She is co-author of the article, "Illness and Injury as Contributors to Bankruptcy," in MarketWatch and as well numerous award-winning books and case books. Professor Warren also serves as the vice president of the American Law Institute and is on the executive committee of the National Bankruptcy Conference.

Our fifth witness is Mark Rukavina. Mr. Rukavina is the executive director of the Access Project, a national resource center. Mr. Rukavina manages multiple aspects of the national program providing technical assistance, information, consulting services, and financial support to community-based efforts to expand health care access and coverage. Prior to that position, Mr. Rukavina was a program director for the Summerbridge community health partnership.

And our final witness is Dr. David Himmelstein. Dr. Himmelstein is associate professor of medicine at Harvard Medical School and practices primary care internal medicine. He serves as a chief of the division of social and community medicine at Cambridge Hospital in Cambridge, Massachusetts. Dr. Himmelstein is also co-author of the "Illness and Injury as Contributors to Bankruptcy" in MarketWatch and has published more than 70 scientific papers, books, and articles.

I want to thank you all for your willingness to participate in today's hearing.

And, without objection, your written statements in their entirety will be placed in the record. So we are going to ask you to limit your oral testimony to 5 minutes.

You will note that we have a system of lights that starts with a green light. That is your signal to proceed. At 4 minutes, it will turn yellow, which is warning you that you have a minute to conclude your testimony. And then when your time has expired, it will turn red.

When your time is up, we will ask you to just finish the current thought that you are on and wrap up the testimony so that we may move on to the next witness and each witness can be heard.

After each witness has presented his or her testimony, Subcommittee Members will be permitted to ask questions subject to a 5-minute limit.

Ms. Smith, are you ready now to proceed with your testimony? Okay, you are recognized for 5 minutes. And you may proceed.

TESTIMONY OF DONNA S. SMITH, HEALTH CARE ACTIVIST, AURORA, CO

Ms. SMITH. Good afternoon, Madam Chair Sánchez and Committee Members. My name is Donna Smith. And I live in the 6th Congressional in Colorado. Representative Thomas Tancredo is my congressman.

I commend Representative Conyers on bringing this issue before you once again and ask that you try and walk a mile in my shoes. It has been a long time since I felt that any of my congressional representatives understood what the current health care crisis is doing to Americans like me.

The last elected official who tried to help was Senator Tom Daschle of South Dakota who spoke about us on the floor of the United States Senate in the spring of 2004 and later offered a sense of the Senate resolution proffering that every American should have access to the same health care coverage as every American and every Member of Congress. The full Senate did not agree. And Americans like me languished onward in a seriously flawed private health care system.

My family's story is included in Michael Moore's new movie, "Sicko." And though Mr. Moore took just 6 or 7 minutes in the film to outline our financial collapse, I can assure you that the health and economic disasters that made us perfect fodder for the film unfolded much more slowly and painfully than depicted on the movie's screen.

I want you to fully consider the plight of families like mine, the hard-working people you purport to represent here in the people's house. I know many of you receive substantial financial support from the health care and pharmaceutical lobbies. But I am asking you to remember that you also received substantial funds from me and all of my fellow American taxpayers through your salaries and benefits.

We the people are your employers. How did this body so remove itself from the reality of the people?

My family is part of a grim statistic in America. Our health care issues and costs drove us to bankruptcy. Yet we were always covered by medical insurance.

The shame of financial failure and bankruptcy should not be the end result of heart and artery disease and cancer. It is enough to fight those hellacious health battles without also fighting for our financial lives. And tonight thousands of Americans will not rest well because they sit on the edge of financial disaster, not because they are slackers or welfare cases or poor people with poor ways.

They sit on the edge because they are sick and you have failed to act on their behalf. I urge you to read my written statement for

more detailed information on our medical and financial march to bankruptcy.

My husband, Larry, and I have been married for 31 years. We have six children and 13 grandchildren. For most of his adult life, Larry was a machinist. I stayed at home with our little ones until our youngest was two. And then I went back to work.

Unhappy working minimum wage jobs, I enrolled in college at the age of 31 while working full-time as a bank teller and caring for my family. I earned my bachelor's degree cum laude and phi beta kappa from Colorado College. I believe in the value of hard work. And my parents, including my World War II veteran father, instilled in me a strong work ethic.

My husband and I always maintained health insurance coverage for ourselves and our children. But our health did not hold up. Larry developed serious coronary artery disease, and I developed uterine cancer.

We struggled against the darkness of bankruptcy for years until there was no other reasonable course. We even carried disability insurance, but that coverage excluded Larry's arteries and heart issues. So it proved of little value in the worst situation.

But over the next several years, health premiums, out-of-pocket expenses, medicine, and doctor visit co-pays combined with a steep reduction in our income forced us into bankruptcy. Our medically-related expenses topped $1,000 each month by the year 2003.

Debt collectors, especially the medical collectors, became rabid. Our bankruptcy in 2004 was the only way to stop the garnishments and the calls. My shame and my depression was difficult to endure.

It was not only medical debt in that bankruptcy. Over the years and months leading to that point we did whatever we had to do to stay afloat. We put food and household items on credit.

We borrowed against older cars. We ordered needed goods from high-interest, high-price mail order firms. So when we reached the point of bankruptcy, all of those debts had to be included. No one was spared.

We tapped out family and friends, begged for community benefits, received food, toothpaste, and toilet paper from a local food pantry. And I was working full-time the whole time.

The worry was exhausting. And the stress did not help the situation. Finally, Larry was fired from his job in the spring of 2004 on his return from surgery at the Mayo Clinic because his employer, the Gold Dust Casino in Deadwood said they could not accommodate his post-surgical lifting restrictions.

The Mayo Clinic wrote, too, and said they were forgiving or writing off the $6,000 left on Larry's bill after insurance payments, but that if we ever wanted to return, we would have to bring the cash up-front for our portion of the cost. Larry hasn't been properly evaluated for his peripheral artery disease since.

I took Larry onto my group health insurance, and he began the application for Social Security disability. His application was approved, but he went 6 months with absolutely no income and had to wait 2 years to qualify for Medicare health coverage. So our financial condition continued its decline.

Congress should also act to fix that deficiency. If an American is found to be too ill to work, making that person wait 2 years for Medicare coverage is cruel and just plain dumb.

I even tried opening a small local business with the help of a small amount of local economic development funds while I continued my full-time work at the newspaper. But the business didn't take off quickly enough. It seemed as if our last hope of saving ourselves was doomed.

Larry got sicker and in February 2006 was told he would need yet another heart surgery. This time it took 12 hours to complete the quadruple bypass at Rapid City Regional Hospital. Larry was in intensive care for days and then home to heal. But that certainly pushed our deductible and out-of-pockets right back out of sight and reach for my income and his Social Security benefits. We were going under all over again just 2 years after bankruptcy.

Finally, we moved in with our grown daughter in Denver. The life we worked so hard to build and the life we fought to save was lost. We had failed. The health care system had crushed us.

Let me say again we are not in "Sicko" because our story is so unique. We are in this film because we are not unique. We represent what is happening to so many other Americans.

I want the Members of this Committee to know that if H.R. 676, Medical for All, had been in place for us, we would have weathered that storm. We are hard working people who under normal conditions make sound money decisions. But placed under the strain of mounting premiums, co-pays, deductibles, and out-of-pockets, we did whatever we had to do to stay alive.

I am so angry with you. I lived the American dream as my father taught me and his father taught him. I worked. I educated myself. I voted. I bought a home and then moved into a better home.

I raised my children responsibly. And I served in my community. And you left me broken and battered because you failed to act on health care reform.

Just as I have come out of the shadows of economic ruin and shame, so, too, will others come forward to hold you accountable. Remember the hard-working people who elected you. Their bankruptcy shame, my bankruptcy shame due to medical crisis really is your shame. You are the body that could have acted and have yet not done so.

The current course of inaction takes no courage whatsoever. And I know each of you has shown courage in stepping up to serve this Nation. I just think many of you lost your way in remembering who elected you and who needs your bravery now.

Please do not ignore those of us who elected you. Please help reduce the bankruptcies filed in this Nation by fixing the broken health care system. We will all be better off, individuals and businesses.

And I dedicate this testimony to that of my brave husband, Larry, and three other Americans who gave me the courage to tell this story to millions with the conviction that it will do some good; to my late father, Howard Boyles, who proudly served his Nation in the United States Army during World War II and who told me that people have died to protect my right and my responsibility to speak up; to Senator Tom Daschle, who took an interest in my fam-

ily and who spoke up in spite of political consequences; and to an eagle scout from Flint, Michigan, named Michael Moore, who restored my dignity and my voice on a movie screen in Manhattan and is keeping his scout's promise to better his community and his Nation.

Please hold real hearings on H.R. 676 and pass universal single payer health care for every American. It is not humane to do otherwise. And your constituents deserve your recognition of their humanity.

Thank you very much.

[The prepared statement of Ms. Smith follows:]

PREPARED STATEMENT OF DONNA S. SMITH

Good afternoon, Madam Chair Sánchez and committee members.

My name is Donna Smith. I live in the 6th Congressional District in Aurora, Colorado. My Congressional representative is Thomas Tancredo.

But it has been a long time since I have felt that any of my Congressional representatives or my U.S. Senators truly understood what the current health care crisis is doing to Americans like me or acted with courage to correct a crisis that is permeating every facet of the American economy.

The last elected official who took my situation seriously and tried to help was Sen. Tom Daschle of South Dakota who spoke about us on the floor of the U.S. Senate in spring of 2004. He would later offer a "sense of the Senate resolution" proffering that every American should have access to the same health coverage as every member of Congress does at the same cost or better. Unfortunately, Sen. Daschle's sense was not that of the full Senate or of the House. And Americans like me languished onward in a private health care system that is driven by profit not health needs.

Recently, filmmaker Michael Moore visited Washington, D.C., to share with some of you the issues and problems featured in his newest film, SiCKO. My family's story is included in SiCKO, and our story represents a horrific set of circumstances unfolding in middle class families across this nation.

Though Mr. Moore took seven or eight minutes in his film to outline our financial collapse, I can assure you that the health and economic disasters that made us perfect fodder for film unfolded much more slowly and painfully than depicted on the movie screen. Mr. Moore and his production staff did not know much of what is shared in this testimony, and I offer it now so that you might more fully consider the plight of middle-class American families—the hard-working people you purport to represent here in the people's House.

And being a part of this film project did not change the cruel reality for us or for any of the others in SiCKO. We were not paid, and the conditions we faced before the film are in most cases very similar to the conditions each of us face today. In order for our story to mean something you must act on our behalf.

I know many of you receive substantial financial support from the health care and pharmaceutical industries, and you may feel hard-pressed to look at any plans that could put those funds at risk. But I am asking you to consider that you also receive substantial funds from me, my neighbors and all of my fellow Americans through your salaries and benefits funded by taxpayer funds and you hold office because we voted for you. We the people are your employers.

I find it unacceptable and even difficult to comprehend how you can sit here and apparently not understand the severity of the problem. How did this body so remove itself from the reality of the people? I commend Rep. Conyers on bringing this issue before you once again and ask that you imagine yourselves walking a mile in my shoes.

My family is part of a grim statistic in America. Our health care issues and costs drove us to bankruptcy as it has driven an estimated half of those filing bankruptcy to that point. And we were always fully covered by medical insurance. By sharing our story and our path to bankruptcy, it is my hope and it is my prayer that each of you will have the courage you must have to act on behalf of your fellow citizens, your constituents and your nation to pass meaningful health care reform.

If you had made HR676 law when it was proposed back in 2003, I would still have my home, my dignity and better health.

Instead, I come to you today, imploring you to act for the thousands like me who elected you and who count upon you to do what is best for our nation. In the course of human events today, bankruptcy should not be the end result of heart disease

and cancer. It is enough to fight those hellacious health battles without also fighting for our financial lives. The shame of financial failure and bankruptcy should not be the end result of needing health care in America. If you think it couldn't happen to you or to your family, think again. And tonight when you lay yourselves down to rest, know that hundreds of thousands of Americans will not rest well because they sit of the edge of financial disaster not because they are slackers or welfare cases or poor people with poor ways. They sit on the edge because they are sick and because you have failed to act on their behalf.

OUR STORY

My husband Larry and I have been married for 31 years, and we have six children and 13 grandchildren. For most of his adult life, Larry was a machinist. I stayed at home with our little ones until our youngest was two and then like so many other American families, we needed the income I could earn and I went back to work.

Unhappy working minimum wage jobs, I enrolled in college and at the age of 31 while working full time as a bank teller and caring for my family, I earned my bachelor's degree, cum laude and Phi Beta Kappa, from Colorado College in Colorado Springs. I believe in the value of hard work, and my parents—including my World War II veteran father—instilled in me a strong work ethic.

Throughout our early years together and at all times thereafter, my husband and I always maintained health insurance coverage for ourselves and our children. It was never our expectation that others care for us. We both stayed well-informed and exercised our right to vote. We owned our own home and stayed actively involved in every aspect of our children's lives.

For you to understand, you must realize that the health-related financial trauma we experienced does not happen overnight. Good, hard-working Americans like us struggle against the darkness of bankruptcy for years until there is no other reasonable course.

Brewing in my husband's body were the bad arteries that also plagued his father. And at age 46, Larry suffered his first significant heart-related difficulties, and he underwent his first heart bypass surgery in January of 1990 at Mercy Hospital in Miami. His recovery was remarkable at first but then quickly reversed. He was wasting away, and by July of 1990, another heart surgeon had concluded that Larry's first heart surgery had been botched. His artery bypass had been placed too "proximal" to the initial site of blockage and as his body built scar tissue, the newly opened vessel quickly closed again.

His original doctors did not tell him this. He was told the bad news by Dr. Jack Greenburg, also of Miami, who then performed another coronary bypass on Larry in July of 1990 just six months after his first. The bills were awful at that time, but we managed to argue with some of the docs that since the second surgery was due to error in the first, perhaps it wasn't quite right to bill us twice for the botched work. We recovered financially from that only after years of argument and bartering. No lawsuit was ever filed for the bad operation since Larry recovered and lawyers didn't see a multi-million dollar case or a sizeable enough cash retainer from us to proceed.

I consider the current argument that medical malpractice insurance rates are driving the current crisis as ludicrous and only to be believed by simple minds with simple ambitions—to protect the powerful and the wealthy by keeping average people from suing. Fixing the health care system for the top tier is as morally wrong as ignorance of the problem, but that's an argument for other, brighter minds than mine.

My husband did recover from those early heart surgeries, though he wasn't nearly as strong. His work would suffer due to his health status in the mid-1990s, but we slowly worked our way back from the brink. He had to give up the physically demanding work of machining and worked more menial jobs—pizza delivery, light maintenance and eventually cashiering. What a decline of dignity for my proud and able husband. Yet he worked doing what he had to do to help support our family.

I was staying relatively healthy although I had been diagnosed with sleep apnea and had to use breathing support at night with both a C-PAP machine and oxygen. But I always worked full time too. And I often took on extra projects or part-time efforts to supplement our income.

But in 1998, Larry's chest pains returned, and he would begin the spiraling downward that ultimately led him to several cardiac procedures, stent placement and another heart bypass surgery (the most recent in February of 2006). Our health insurance premiums were paid through our separate employers based on the most economical and comprehensive coverage we could purchase through these years, 1990–

2003. Monthly premiums ranged from $150 to $250 for each of us and though the cost seemed high based on our wages, we paid. In the meantime, his need for daily medications was also increasing.

Late in 1999, I reluctantly went to my nurse practitioner with what I thought was early-menopausal symptoms. She was going to prescribe some hormonal therapy to control severe bleeding but then decided I should be seen by an OB/GYN. Thank God her intuition told her to take that course. Within a couple of weeks, I was diagnosed with uterine cancer. It was off to surgery and treatment for me. And I lost weeks of work with no way to recover the income. Friends and co-workers donated money to help us, but by now our medical problems were taking a heavy financial toll.

Just weeks after cancer surgery, I returned to work where I was caring for developmentally disabled young people in a group home setting. I knew I couldn't afford to lose more time from work, and I absolutely could not risk losing my health coverage, so I went back to the heavy lifting (some of the youngsters weighed more than 100 pounds and needed full assistance with basic life functions). It was way too soon to return to that sort of work, and though I wore an abdominal brace and a back belt to hold my gut together, I developed a huge abdominal hernia in my cancer surgery incision site and was back to surgery by the summer of 2000.

This time I didn't dare miss much time from work. Just six days after my release from the hospital, and against medical advice, I bound my now-surgically-meshed belly together and returned to work. I simply could not lose the pay and benefits.

In the meantime, Larry's artery problems had extended from already serious coronary artery disease requiring intervention nearly every six months or so to include peripheral artery disease. He was still working full time as a cashier in a Deadwood casino named Gold Dust. Because western South Dakota did not at that time have vascular specialty groups capable of performing the tests Larry needed and because our insurance carrier, DakotaCare, had a contractual arrangement with the Mayo Clinic in Rochester, Minn., that's where Larry was sent for further evaluation.

Because I could not afford to miss any more work, he went alone the first time—driving more than 600 miles alone to see the doctors who could potentially treat him. I tracked his progress by watching ATM transactions on our bank account as he went from place to place on his journey. We had no cell phone or way to contact each other without incurring more expense.

During this period, our insurance premiums mushroomed (in part because we were a part of our employers' group health risk pools). We also now needed several prescription medications each month, and our deductibles and out-of-pocket exposure soared to thousands every year.

By fall of 2003, we had already sold our modest home to fund our loss of income due to Larry's absences from work and to pay off some of our growing debt. We netted only $8,000 from the sale. And our monthly health costs (health insurance premiums, medicine co-pays, out-of-pocket expenses and transportation) swelled to over $1,000.

We borrowed money from friends and family, sometimes launching our own benefit campaigns. It was sickening to beg for money, though folks generally helped without judgment.

When we left for our second trip to the Mayo Clinic, all of our worldly goods went into storage, we had no permanent home and we knew only that if Larry was to live, we needed to do whatever necessary to make that happen. We spent Thanksgiving of 2003 alone in Rochester, Minn., waiting for Larry's first of two surgeries on his iliac arteries. We left the Mayo Clinic just six days after his surgery and drove home to South Dakota to get me back to work. He was so ill during the drive that we stopped at nearly every rest stop and then made a local hospital the first stop back home before checking into a motel where we would live during his recovery.

By now, Christmas of 2003, debt collectors had become rabid. They called me at work, they demanded sums I could not pay and even with explanations of our medical situation, they pursued me very aggressively. When a collector representing a Rapid City doctor

who had already been paid thousands by my insurance company served me with garnishment papers; I thought I would die of humiliation and terror. My husband was very ill. I needed to keep up his insurance and medications, and if I were garnished, I would not be able to meet that obligation to the man I love.

We sought the advice of a local attorney to see if we could negotiate something with this doctor, but to no avail. Bankruptcy was the only way to stop the garnishment. Even as quickly as the attorney moved to complete his work, one pay period's worth of garnishment payment was collected from my check. I was horrified as I was now the local newspaper editor, and being garnished was simply not good on

many levels. But the bankruptcy went through in the spring of 2004, and the calls stopped—at least until the next round of medical issues and until the bills begin building again.

It was not only medical debt in that bankruptcy. Over the years and months leading to that point, we did whatever we had to to stay afloat. We put food and household items on credit, we borrowed against older cars, we ordered needed goods through high-interest, high-priced mail order firms. So when we reached the point of bankruptcy, all of those debts had to be included. No one was spared. So our problems with extreme medical costs and the resulting bankruptcy hurt a wide variety of businesses and individuals. Collateral damage of the national health care crisis, I suppose.

We had tapped out family and friends, begged for community benefits, received food from a local food pantry and yet we were still working. Every available amount of expendable income went to medical needs—even rent, utilities and food took a back seat. Larry tried his hardest to keep going. His employer followed only the absolute letter of law in terms of Family Medical Leave time off for illness and did nothing to help him. It was very clear that they wanted Larry off of their group health insurance sooner rather than later. The worry was exhausting, and the stress did not help the situation. My sleep diminished to just two or three hours each night as I worried myself sick about what would happen and how I could possibly keep Larry from feeling what I felt.

In April 2004, we returned to the Mayo Clinic for the third and final time. Larry had surgery yet again. This time he was told he could return to work in six weeks but no heavy lifting was allowed. Without any prior notification as is required by the law and on the exact date when his 12-week Family Medical Leave for 2004 was exhausted, and by way of a certified letter, Larry was fired from his job. They said that to accommodate his lifting restriction would be too tough for them.

We sobbed together. The end of a working man's life was reduced to a letter full of lies delivered on Memorial Day 2004.

In the meantime, the Mayo Clinic wrote too and said that they were writing off or forgiving the $6,000 left on Larry's bill after the tens of thousands in insurance payments but that if we ever wanted to return, we would have to bring the cash up-front for our portion of the costs. That ended our ability for Larry to return to that fine facility, and he hasn't been properly evaluated for his peripheral artery disease since.

I took Larry onto my group health insurance, and he began the application for Social Security Disability. His application was approved, but he went six months with absolutely no income and had to wait two years to qualify for Medicare health coverage, so our financial condition continued its decline. Congress should also act to fix that deficiency. If an American is found to be too ill to work, making the person wait two years for Medicare coverage is cruel and just plain dumb.

I even tried opening a small local business (with the help of a small amount of local economic development funds) while I continued my full time work at the newspaper, but the business didn't take off quickly enough. It seemed as though our last hope of saving ourselves was doomed. But we aren't quitters, and we sure gave it our all in every way we could think of to pull ourselves out of the financial quagmire.

Larry got sicker still and in February 2006 was told he would need yet another heart surgery. This time it took surgeons 12 hours to complete the quadruple bypass at Rapid City Regional Hospital. Larry was in intensive care for days and then home to heal. But that certainly pushed our deductible and out-of-pockets right back out of sight and reach for my income and his Social Security benefits. We were going under all over again just two years after our bankruptcy.

One of our grown children offered to have us move into her home in the Denver area, and we decided that we had to throw in the towel once and for all.

The life we worked so hard to build and the life we fought to save for the past few years was lost. We had failed. The health care system had crushed us.

Michael Moore's film crew came to South Dakota and documented our move. And they did so because they felt we represented middle class Americans who though fully insured can still lose everything because of health crisis. We packed up our stuff and the dog and drove to Denver. I left the editing and reporting I loved and the beautiful Black Hills of South Dakota.

Let me say again, we are in SiCKO not because our story is so unique. We are in this film because we are not unique—we represent what is happening to so many others Americans. That is sad for us all. I worry every night that somewhere out there sits a woman like me who is at the end of her rope and has nowhere to turn. She works, so she earns too much for government-based help that do not allow for extreme medical emergency, but her pay after paying her insurance premiums is not

enough to support her family. And tonight she'll sit alone and hurting, not knowing that I pray for her and for her strength to face another day.

I want the members of the committee to know that if HR676, Medicare for All, had been in place for us, we would have weathered the storm. We are hard-working people who under normal conditions make sound money decisions. But placed under the strain of mounting premiums, co-pays, deductibles and out-of-pocket costs, we did whatever we had to do to stay alive.

I am so angry with you. I lived the American dream as my father taught me and as his father taught him. I worked, I educated myself, I voted, I bought a home and then moved up into a better home, I raised my children responsibly and I served in my community—and you left me broken and battered because you failed to act on health care reform.

And out there today are hundreds of thousands of people struggling to make ends meet at the same time they are dealing with cancers and heart attacks and all manner of terrible personal health crisis and yet you still fail to act. These people are average, middle class Americans like me who want nothing more than to live a good and decent life surrounded by friends and family in a modest home with enough income to make ends meet.

I am also a Christian. And I do not know what type of Christianity, if any, the current system represents. I hear a lot about family values and respect for human life, but are those just empty words said to placate the religious right voting block or the powerful pro-life lobby? Other good and decent Christians might not share your blind devotion to those points of view. The Christ I learned about as a child attending Arlington Heights First United Methodist Church in Illinois and the Christ I continue to hear about in Sunday services at Cherry Creek Wesleyan Church in Colorado would not allow this to happen to the sick. In fact, I don't think I've heard of any religious group that would allow the sick to be so deeply wounded—and especially not at the hands of other believers. I am asking you to value life and to value it outside the womb too.

And my lobby group will be growing more powerful too. Just as I have come out of the shadows of economic ruin and shame, so too will others come forward to hold you accountable. My faith demands that I love God with all my heart, and to do that I must love my neighbors and care enough to speak up for those too downtrodden to speak for themselves.

But I can only speak here today. You have the power to carry this onward to action. I ask you to search you hearts and your own value systems. Remember hard-working people, put yourselves in the shoes of your constituents and act accordingly. Their bankruptcy shame due to medical crisis really is your shame. You are the body that could have acted and has not. Move forward now, and please do not wait for a new president or for favorable political winds. That course takes no courage whatsoever, and I know each of you has shown courage in stepping up to serve this nation. I just think many of you have lost your way in remembering who elected you and who needs your bravery now.

I dedicate this testimony to my brave husband and three other Americans who gave me the courage to tell this story to millions and the conviction that it can do some good:

To my late father, Howard Boyles, who proudly served his nation in the United States Army during World War II and who told me that people have died to protect my right and responsibility to speak up; to Sen. Tom Daschle, who took interest in my family and who spoke up in spite of political consequences; and to an Eagle Scout from Flint, Michigan, named Michael Moore who restored my dignity and my voice on a movie screen in Manhattan and is keeping his Scout's promise to better his community and his nation.

And I am asking each of you to honor these Americans with me. Honor them by pushing this House to action. Please do not ignore those of us who elected you. Please help reduce the bankruptcies filed in this nation by fixing the broken health care system. We will all be better off—individuals, small businesses and even your corporate friends.

Please hold hearings on HR676, and pass universal, single-payer health care for every American.

Thank you.

Ms. SÁNCHEZ. Thank you, Ms. Smith, for your courage in coming here today to testify. I know it is painful, but we are very mindful of the message that you are bringing.

At this time, I would like to invite Mr. Zywicki to begin his testimony.

TESTIMONY OF TODD J. ZYWICKI, GEORGE MASON UNIVERSITY SCHOOL OF LAW, ARLINGTON, VA

Mr. ZYWICKI. Madam Chairwoman and distinguished Members, it is my pleasure to testify today on the subject of medical debt and bankruptcy. I commend this Subcommittee for seriously studying this question.

Medical debt, medical problems, and the rising costs of health care are a source of concern for many families today. And sadly these problems sometimes land them on the steps of America's bankruptcy courts. It is precisely to deal with these sorts of misfortune and temporary financial setbacks that we have our honored American tradition of the fresh start to allow workers and families to get back on their feet.

At the same time, we are all aware of the economic impact that bankruptcy can have on those conscientious doctors, nurses, hospitals, and other health care providers who deliver our babies and even save our lives and those of our loved ones in times of crisis. They are entitled to be paid for their valuable services that they provide.

Although it is just and appropriate to preserve the fresh start for those overwhelmed by health problems and medical costs, we should keep in mind that when some are unable to pay their medical debts, those costs must be passed on somewhere else within the health care system, either to insurers and patients through higher costs for services or through lower quality care, innovation, and choice. There is no free lunch.

Consider that every $100,000 discharged in bankruptcy may make the difference between a hospital being able to afford an additional nurse for a year or improved patient treatment. Indeed, elementary economics suggest that on a macro-economic level, an increase in uncollectable medical debts may exacerbate the problem of rising health care costs in the economy.

Addressing the issue of health care and bankruptcy thus requires striking a delicate and complicated balance between the needs of innocent families who find themselves in dire straits because of medical problems on one hand and the claims of innocent doctors, nurses, and hospitals that provide needed and even lifesaving health services on the other.

At the current time, there is little evidence that medical bankruptcies are creating some sort of crisis for the bankruptcy system or that the frequency of medical bankruptcies has been rising over time. Current data is sparse and provides a tenuous basis for sweeping reforms. And further research is needed. But current data does suggest a few tentative conclusions.

First, some medical data is present in many bankruptcy cases, perhaps approximately half of cases.

Second, in a relatively small number of cases, large medical debts are the primary cause of bankruptcy filings.

Third, in some cases, medical debts combined with other debt such as mortgage, automobile or credit card debt to lead to a bankruptcy filing.

Fourth, in the overwhelming majority of cases, there is either no medical debt at all, or the amount of medical debt present is rel-

atively small and unlikely to be the proximate cause of the debtor's bankruptcy.

Fifth, bankruptcies are insured in general at the same rate as the general population.

Finally, although medical problems theoretically can also contribute to bankruptcy by leading to unexpected job loss or income interruption, empirical studies suggest that this is not a significant cause of bankruptcies and the number of bankruptcies attributable to this cause does not appear to be growing over time.

Current law strikes an appropriate balance of these competing concerns between innocent doctors and innocent patients. Two years ago this body enacted the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 by a bipartisan 70 percent majority. BAPCPA should be given an opportunity to prove itself before Congress once again reopens the question of bankruptcy reform, especially in light of the lack of any concrete evidence to indicate a pressing problem.

Under the means testing provisions of BAPCPA, low-income debtors, including those who are unable to work because of health problems, are entitled to file bankruptcy and discharge their unsecured debts, whether medical or otherwise. High-income debtors who can repay a substantial portion of their debts without significant hardship are required to enter a Chapter 13 plan and repay as much as they can of their unsecured debts as a condition for filing bankruptcy, whether 40, 60 or 80 percent of their outstanding unsecured debt.

Moreover, in calculating the debtors' income available to repay debts in Chapter 13, the law permits a deduction for health insurance and other health expenses. Finally, a judge retains discretion to permit an otherwise ineligible debtor to file a Chapter 7 if she can show special circumstances such as notably a serious medical condition.

In short, current law adequately accommodate the claims of those debtors laid low by medical problems and expenses and other innocent parties who are affected by bankruptcy, including health care professionals and other health care consumers. It asks debtors to pay what they can and health care providers, consumers, and insurers to absorb the remaining costs.

Although BAPCPA seems to be accommodating these concerns, it has been in operation for less than 2 years. Future research may suggest propriety of reconsideration of the issue.

Finally, we should note that as a result of BAPCPA, the bankruptcy filing rate has been cut about in half, at least temporarily. To the extent that BAPCPA has succeeded in weeding out fraudulent and abusive filings, which it appears to have done, it would be expected that a greater percentage of cases today than in the past would involve true medical bankruptcies, even if the absolute number of such filings has not increased. Indeed, the primary effect of BAPCPA appears to have been to reduce the denominator on the filings ratio thereby leading to an increased percentage of legitimate filings, including medical bankruptcies.

In conclusion, allow me to offer that if this Committee's true concern is not with medical bankruptcies, but with the cost or quality of health care in America in general, an issue on which I express

no opinion today, it seems obvious to me that tinkering with the bankruptcy code is one of the least effective ways imaginable for dealing with those issues.

Thank you.

[The prepared statement of Mr. Zywicki follows:]

PREPARED STATEMENT OF TODD J. ZYWICKI

TESTIMONY OF PROFESSOR TODD J. ZYWICKI PROFESSOR OF LAW GEORGE MASON UNIVERSITY SCHOOL OF LAW

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Before the
United States House of Representatives
Committee on the Judiciary
Subcommittee on Commercial and Administrative Law

Hearing on
"Working Families in Financial Crisis: Medical Debt and Bankruptcy"

Tuesday July 17, 2007

1:00 pm

Room 2141 Rayburn House Office Building

This testimony with all Figures and the academic articles referenced herein are available for download on my website at http://mason.gmu.edu/~tzywick2/.

Mr. Chairman and Distinguished Members:

It is a pleasure to testify here today on the subject of "Working Families in Financial Crisis: Medical Debt and Bankruptcy." Medical debt and medical problems are a source of concern for many American families today and sadly these problems sometimes land American families on the steps of America's bankruptcy courts. It is precisely to deal with these sorts of bad luck and temporary financial setbacks that we have our honored American tradition of the fresh start, to allow workers to get back on their feet.

On the other hand, these concerns have been long-recognized by this body in American bankruptcy law, and are systematically accommodated in current bankruptcy law, including the amendments enacted two years ago by this body with a bipartisan 70% majority in the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA"). For every innocent debtor who has found himself down on his luck as the result of illness and injury, there are also innocent doctors, nurses, and health care professionals who have provided ameliorating and even life-saving care for the debtor. When some bankruptcy filers don't or can't pay their bills, those losses are passed along in the health care system through higher prices for insurers and other consumers or reduced medical services and quality. Every $100,000 discharged rather than paid in bankruptcy may be the difference between a hospital hiring a new nurse or the ability of a doctor to afford indigent care for another patient.

Current law strikes an appropriate balance of these competing concerns between doctors and patients. Under the means-testing provisions of BAPCPA, low-income debtors, including those who are unable to work because of health problems, are entitled

to file bankruptcy and discharge their unsecured debts, whether medical or otherwise. High-income debtors who can repay a substantial portion of their debts without significant hardship are required to enter a Chapter 13 plan and repay as much as they can of their unsecured debts as a condition for filing bankruptcy, whether 40%, 60%, or 80% of their outstanding unsecured debt. Moreover, in calculating the debtor's income available to repay debts in Chapter 13, the law permits a deduction for health insurance and other health expenses. Finally, a judge retains discretion to permit an otherwise-ineligible debtor to file in Chapter 7 if she can show special circumstances, such as "a serious medical condition."

In short, current law adequately accommodates the claims of those debtor laid low by medical problems and expenses and other innocent parties who are affected by bankruptcy including health care professionals and other consumers. Nor is there any evidence that medical bankruptcies are creating any sort of crisis for the bankruptcy system or that the percentage of medical bankruptcies has been rising over time. Current law balances these concerns well and it is not clear what reforms are necessary at the current time. If this Committee's true concern is not with medical bankruptcies but with the cost or quality of health care in America in general, an issue on which I express no opinion, it seems obvious to me that tinkering with the Bankruptcy Code is one of the least effective ways imaginable for dealing with those issues.

I have taught and written extensively on questions related to credit cards, consumer credit generally, and the relationship between consumer credit and consumer bankruptcies. See *An Economic Analysis of the Consumer Bankruptcy Crisis*, 99

NORTHWESTERN L. REV. 1463 (2005)[1] and *Institutions, Incentives, and Consumer Bankruptcy Reform*, 62 WASHINGTON & LEE L. REV. 1071 (2005).[2] I am currently working on a book on consumer credit and consumer bankruptcy tentatively titled *Bankruptcy Law and Policy in the Twenty-First Century* to be published by the Yale University Press, from which portions of this testimony are drawn. I am honored to have the opportunity to share my research with you here today. From 2003-2004 I served as Director of the Office of Policy Planning of the Federal Trade Commission.

HOW MANY BANKRUPTCIES ARE "MEDICAL BANKRUPTCIES"?

Health problems theoretically can lead to a household filing bankruptcy in two ways, by reducing the ability to work and thus creating an unanticipated disruption to a family's income flow, or an unanticipated budget shock to expenses through high uninsured medical bills. In some cases medical problems can create both shocks simultaneously, creating a whipsaw effect of both an unexpected income loss and unexpected medical bills. In other cases the two effects may offset each other to some extent, if for instance, increased expenditures produces higher quality care which results in shortened convalescent periods or fuller recoveries, reducing the amount of missed income for a worker.

Thus, medical problems can in theory be a unique contributor to household bankruptcy and surely some bankruptcies are caused by this factor. On the other hand, it is not clear exactly how many consumer bankruptcies are attributable to this factor, nor is

[1] Available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=587901.
[2] Available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=681483.

there any evidence that the problem of medical bankruptcies is increasing over time. Consider each possible explanation in turn.

There is No Evidence That There Has Been An Increase in the Frequency or Severity of Job Loss or Income Interruption as a Result of Health Problems

The first way in which medical problems could lead to increased bankruptcies is by an increase in the frequency or severity of job loss or income interruption as the result of health problems.[3] Although this surely is the cause of some bankruptcies, there is no evidence that this is an important contributor to many bankruptcies. A study by Ian Domowitz and Robert Sartain, for instance, find little correlation of medical debt with other sources of financial distress, such as job loss or income interruption.[4] Fay, Hurst, and White find that health problems by the head of a household or spouse that cause missed work are *not* a statistically significant factor in bankruptcy filings.[5] Aparna Mathur similarly finds that poor health by the head of the household is not a statistically significant predictor of bankruptcy filings.[6] She also reports that only six percent of participants in the Panel Study of Income Dynamics survey self-reported that illness or injury caused their bankruptcy filing and statistical analysis found no significant correlation between bankruptcy filings and individuals in poor health.

These findings are not surprising. Extraordinary advances in medical technology have dramatically shortened the recovery time and reduced complications for virtually

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[3] *See* Aparna Mathur, *Medical Bills and Bankruptcy Filings*, American Enterprise Institute (2005), *available in* http://www.aei.org/docLib/20060719_MedicalBillsAndBankruptcy.pdf (finding that losing work days due to illness significantly increases the likelihood of filing bankruptcy).

[4] Ian Domowitz & Robert L. Sartain, *Determinants of the Consumer Bankruptcy Decision*, 54 J. FIN. 403, 413 (1999).

[5] Scott Fay et al., *The Household Bankruptcy Decision*, 92 AM. ECON. REV. 706, 714 (2002).

[6] *See* Mathur, *Medical Bills and Bankruptcy Filings* (summarizing findings of PSID).

every medical procedure over the past few decades, thereby reducing the amount of missed work time and hastening a fuller recovery to previous levels of productivity. Thus, while some people are forced to file bankruptcy because of job loss or interruption as the result of illness or injury, it is doubtful that this number is growing over time.

Moreover, American households should be much more resilient to temporary income interruptions than in previous eras. The past two decades have seen record accumulations of household wealth (in stocks during the 1990s and in home values throughout the past two decades) and an increased ability to access that wealth in times of need (through the development of home equity lines of credit, for instance), that should cushion income interruptions. Moreover, the increasing number of two wage-earner families obviously has made families more resilient in the face of the loss of one income as the result of job interruptions from health problems or any other source. Thus, there is little reason to believe that during recent decades there could have been an increasing number of medical bankruptcies as a result of an increase in the frequency or severity of employment interruptions and consequent unexpected income loss. As noted, empirical studies do not identify this factor as an important one and, if anything, the contribution of this factor to the frequency of bankruptcies likely has declined over time.

There is Little Evidence That Medical Debt Is a Major Causal Factor in Bankruptcy Filings

Second, there is no evidence that there has been an increase in the number of bankruptcies caused by medical debt. Many empirical studies over the past several decades have tried to measure the number of bankruptcies attributable to medical

problems. Most studies of bankruptcy filers have failed to find a relationship between health debt and bankruptcy, although medical debt does play a role in some bankruptcy filings.[7] Most studies find no medical debt at all in about half of consumer bankruptcy filings and in the overwhelming number of cases where medical debt is listed it is relatively small in amount and unlikely to be a significant contributor to the bankruptcy filing.

A recent study of bankruptcy filers by the Department of Justice's Executive Office of the United States Trustee (USTP) is consistent with the findings of most studies. The USTP examined the records of 5,203 bankruptcy cases filed between 2000 and 2002, the most thorough study of the problem to date of those who actually filed bankruptcy. It reported that 54 percent of the cases in the sample listed no medical debt, meaning that the median amount of medical debt in the study was zero. Medical debt accounted for 5.5 percent of total general unsecured debt and 90.1 percent reported medical debts less than $5,000. There were a few cases where extremely high medical debt likely explained the subsequent filing—one percent of cases accounted for 36.5% of medical debt and less than 10 percent of all cases represented 80% of all reported medical

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[7] *See* TERESA A. SULLIVAN ET AL., AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA 168-69 (1989); Barry A. Gold & Elizabeth A. Donahue, *Health Care Costs and Personal Bankruptcy*, 7 J. HEALTH POL., POL'Y & L. 734 (1982) (finding that medical debts are not a major cause of bankruptcy); Philip Shuchman, *The Average Bankrupt: A Description and Analysis of 753 Personal Bankruptcy Filings in Nine States*, 88 COM. L.J. 288, 294–96 (1983) (finding medical debt scheduled in over half of bankruptcies and median medical debt of $567); Philip Shuchman, *New Jersey Debtors, 1982–83: An Empirical Study*, 15 SETON HALL L. REV. 541, 570–71 (1985) (finding average amount of medical bills as expressed as a percentage of total unsecured debt "was relatively small"—five percent of total unsecured debt); Larry Sitner et al., *Medical Expense as a Factor in Bankruptcy*, 52 NEB. ST. MED. J. 412 (1967) (finding medical debts not to be an important factor in most bankruptcies); *see also* Melissa B. Jacoby et al., *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 378 (2001) (noting that "[u]ntil the 1990s . . . most empirical studies of bankruptcy did not find illness, injury, or medical debt to be a major cause of bankruptcy"). *But see* Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L.J. 675, 709–721 (1991) (finding large amounts of medical debt and medical debt present in many cases in her sample, but noting limited ability to generalize from her judgment-proof debtors to the larger population of Americans or bankruptcy filers).

debt. Of the minority of cases in the sample with medical debt, the average medical debt was $4,978 per case, 78.4 percent reported medical debts below $5,000 (an average of $1,212 for this group), and medical debts accounted for 13.0 percent of the total general unsecured debt for those reporting medical debt. Thus, even among those who reported medical debt, few reported medical debt levels sufficiently high to conclude that they were a primary cause of bankruptcy.

Aparna Mathur's study using data from the Panel Study of Income Dynamics from the 1990s similarly finds little support for the claim that medical debt is the leading cause of bankruptcy filings. Only 9 percent of respondents in the PSID claimed medical debt as the primary reason for filing and 7 percent claimed it as a secondary reason. Her statistical analysis found that medical debts substantially contributed to 27 percent of all bankruptcy filings at most, but that medical debts had an impact on bankruptcies primarily when *combined* with other high levels of consumer indebtedness such as credit card debts or automobile debt. Where households were not otherwise heavily indebted, the addition of medical debt alone had a minimal effect on the likelihood of filing bankruptcy. As Mathur concludes, "We find that households with medical debts, *in addition to other debts*, are the most likely to file, while those with *primarily* high medical debts explain relatively few bankruptcy filings." Thus, the contribution of medical debt alone to bankruptcy is difficult to determine.

Notwithstanding the longstanding consensus that relatively few bankruptcies can be reasonably said to be caused by health problems and health costs, a recent study nonetheless concludes that approximately half of consumer bankruptcies are caused by

medical problems, a twenty-three-fold increase over a twenty-year period.[8] Both conclusions are fundamentally unsupportable, however, and rest primarily on the way in which the researchers define and count what constitutes a medical bankruptcy rather than an actual increase in the number of bankruptcies caused by medical problems. The study's methodology and conclusions have been uniformly criticized by health scholars[9], economists[10], and law professors[11]. Indeed, I have been unable to locate any independent researcher unaffiliated with any of the authors of the study who has endorsed the methodology or findings of this study.

The problems with the study's methodology and conclusions are extensive but are not difficult to identify. As a result, I will simply provide a summary of the most glaring problems here and refer the Committee to sources cited elsewhere in this testimony for a more extensive discussion. As noted, the researchers' methodology has been roundly and uniformly criticized.

First, the finding that half of all bankruptcies are caused by medical problems is based on a fundamentally flawed and over-expansive definition of "medical

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[8] *See* David U. Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5–63, *available at* http://www.content.healthaffairs.org/webexclusives.

[9] *See* David Dranove and Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25(2) HEALTH AFFAIRS 74 (2006); *see also* Kevin C. Fleming, *Author's Conclusions Not Supported by Study Results*, HEALTH AFFAIRS eLetters (Feb. 16, 2005); Jeff Lemieusx, *A Cautionary Note o the Number of Health-Related Bankruptcies*, HEALTH AFFAIRS eLetters (Apr. 13, 2005).

[10] Aparna Mathur, *Medical Bills and Bankruptcy Filings*, American Enterprise Institute (2005) (criticizing definition of medical bankruptcies as "too broad," noting absence of control group, and concluding that the actual number of medical bankruptcies is "much smaller" than reported in Himmelstein study).

[11] Gail L. Heriot, *Misdiagnosis: A Comment on* Illness and Injury as Contributors to Bankruptcy *and the Medial Publicity Surrounding It*, 10(1) TEX. REV. L. & POLITICS 229 (2005); Todd J. Zywicki, *An Economic Analysis of the Consumer Bankruptcy Crisis*, 99 NORTHWESTERN L. REV. 1463, 1518-19 (2005); Todd J. Zywicki, *Health Problems and Bankruptcy: Are 50% of Bankruptcies Health Related?*, Volokh Conspiracy, *at* http://volokh.com/archives/archive_2005_02_13-2005_02_19.shtml#1108558247 (Feb. 16, 2005, 6:50 EST).

bankruptcies."[12] The researchers, for example, count as "medical bankruptcies" such events as gambling addiction, a death in the family, or the birth or adoption of a child, in addition to unexpected illness or injury. Many of these are open to question as to whether they are properly classified as medical bankruptcies. As Professor Gail Heriot notes, "Babies are a financial hardship even when hospitals given them away free" and it is hard to see how it is the medical bills that are to blame for a subsequent bankruptcy—and still less so when the even is an adoption. Moreover, although some substance abusers and gamblers are addicts, it is not clear why all those who gamble their way into bankruptcy should be assumed to be gambling addicts and thus classified victims of "medical bankruptcy"

Moreover, they count as a serious medical problem any accumulation of unpaid medical bills of over $1000 within two years of bankruptcy. This figure is obviously too low of a threshold to try to capture the phenomenon of "medical bankruptcies." To put this figure in perspective, in 2001 average per capita out of pocket health expenses were $683—meaning that during that period the average American spent about 30% more than this figure on unreimbursed medical expenses.[13]

The researchers also report the mean amount of medical debt, which could be skewed by a handful of high-debt filers and is irrelevant to the question as each person can only file bankruptcy once during the sample period.[14] They do not report any

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[12] *See* Mathur ("their classification of a medical bankruptcy is too broad"): Fleming ("the very definition of 'medical bankruptcy' in this study is a poor one"); Lemieusx (calling definition of health care bankruptcies "very broad").

[13] . *See Health Accounts, at* http://www.cms.hhs.gov/statistics/nhe/default.asp. Overall, in 2001, average private medical expenditures were almost $2500 per person for total private medical expenditures (including payments on health insurance premiums). *Total* expenditures by individuals, employers, government, and philanthropy were over $5000 per person for 2001.

[14] They state elsewhere that their finding of out-of-pocket costs of $11,854 "indicates that most families had incurred far more than $1,000 in out-of=pocket costs." Himmelstein et al., *Bankruptcy and Health:*

evidence on how many filers had substantially more than $1000 in unpaid medical bills, the median amount of medical debt, nor the distribution of debt—even after Dranove and Millenstein specifically identified this methodological flaw.[15] In fact, as noted above the study by the United States Trustee found relatively few filers with substantial medical bills and a very small number of filers with very large medical debts. Himmelsein, et al., provides *no* reason to question this conclusion that the problem of large medical debts is limited to a relatively few number of filers.[16]

They also do not control nor even provide any evidence as to the size of the other obligations of the "medical bankruptcy" filers. Thus, for instance, a debtor with $1001 in unpaid medical bills and $50,000 in student loan debt or tax debt would classify as a medical bankruptcy under the authors' definition. It is not clear why this hypothetical situation would be classified as a medical bankruptcy.

Finally, they do not attempt to control for the possibility of strategic behavior as part of pre-bankruptcy planning, such as decisions by debtors to pay secured debts, such as mortgages or automobile loans, or nondischargeable unsecured debts, such as student loans, instead of medical debt, which is generally unsecured and dischargeable. Such strategic decisions would tend to inflate the amount of medical debt in bankruptcy relative to its actual proportion outside bankruptcy.

The Authors Reply, HEALTH AFFAIRS eLetters (June 8, 2005). But this inference obviously does not follow—a high *average* amount of health expenses could arise *either* from each filer having substantial medical debt or from a few filers who have extremely high medical debt that pulls up the average for all. The United States Trustee study indicates that the latter scenario is more plausible than the former. Again, the authors provide no evidence regarding the median or distribution of medical debt in their study so they have no basis for the inference that they claim is "indicated" by the data.

[15] Dranove and Millenstein at p. W77.

[16] The United States Trustee's office also examined almost three times as many petitions as the Himmelstein study.

Nor are the authors' conclusions supportable, even leaving aside the obvious methodological flaws in the study. Among their conclusions are that: "Medical problems contribute to about half of all bankruptcies"; "that the number of medical bankruptcies had increased twenty-threefold by 2001"; and , "since the number of bankruptcy filings rose 11 percent in the eighteen months after the completion of our data collection, the absolute number of medical bankruptcies almost surely continues to increase." All of these conclusions are open to question.

First, the finding that approximately half of all bankruptcies are caused by medical problems is unsupportable. Dranove and Millenson note that 28.3 percent of respondents in the study stated that illness or injury was a cause of bankruptcy, and that the remaining "medical bankruptcies" arose through the authors' classification of medical bankruptcies. As noted, the authors define this second category of bankruptcies unduly broadly. In fact, Dranove and Millenson a more reasonable interpretation of Himmelstein's data suggests that about 17 percent of their sample had medical expenditure bankruptcies and that even then it is not possible to conclude that medical spending was the most important cause of bankruptcy. In fact, this estimate of about 17% approximates the higher end of the range of findings of other studies of bankruptcy filers as to the contribution of medical expenses to bankruptcy. There also is no evidence that this figure has been growing over time. For instance, Mathur reports that in the PSID data she studied, 9 percent of those surveyed self-reported medical bills as the primary reason for filing and 7 percent claimed medical bills as a secondary reason, for a total of 16%.

Second, the finding of a twenty-three-fold increase in medical bankruptcies is equally unsupportable. This figure appears to be almost completely the result of a change in the way in which the researchers define medical bankruptcies. The baseline for the purported twenty-three-fold increase was a finding in the book *As We Forgive Our Debtors* that only eight percent of bankruptcies were medically-related.[17] It is not exactly clear what was considered to be a "medical bankruptcy" in the earlier study, but it appears that the definition was much narrower, and did not include such things as gambling addiction or the $1000 threshold. If the $1000 threshold was actually included in the earlier study, the authors of the current study do not appear to have adjusted it for inflation or growth in income.[18] In fact, *As We Forgive Our Debtors* seems to directly reject the more expansive definition of "medical bankruptcies" of the current study, stating:

> Our central finding is that crushing medical debt is not the widespread bankruptcy phenomenon that many have supposed. To the extent that the typical debtors in bankruptcy are painted as sympathetic characters because they are struggling with insurmountable medical debts, these data show that "typical" is the wrong adjective. *Only a few debtors find themselves in such extreme circumstances . . . . About half of all debtors carry some medical debt, and many carry substantial medical debt. Although these medical debts are not the obvious cause of the debtors' bankruptcies, they are part of their financial troubles.*[19]

The earlier study, like the most recent one, therefore, found medical debt *present* in about half of bankruptcy filings. By contrast, the earlier study concluded that relatively small amounts of medical debt were unlikely to be a significant cause of

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[17] Himmelstein et al., *supra* note 8, at W5-71.

[18] Per capita income rose from $8476 to $22,851 per year from 1981 to 2001. *See* U.S. Census Bureau, *Historical Income Tables—People, Table P-1, at* http://www.census.gov/hhes/income/histinc/ p01ar.html (last visited Aug. 1, 2005). Mean household income rose from $22,787 to $58,208. U.S. Census Bureau, *Historical Income Tables—Households, Table H-9, at* http://www.census.gov/hhes/ www/income/histinc/h09ar.html (last visited Aug. 1, 2005).

[19] SULLIVAN ET AL., at 173 (emphasis added).

bankruptcy. The authors added, "The central finding is that medical debt is not an especially important burden for most debtors."[20] This earlier approach seems much more reasonable than that today.

Third, the authors also report that bankruptcy filings rose 11% in the period after the completion of their data collection, meaning that the "absolute number of medical bankruptcies almost surely continues to increase." Since BAPCPA went into effect about two years ago, however, bankruptcy filings have fallen approximately 50%-70%. If the authors were right about their earlier claim that a continued rise in the bankruptcy filing rate signaled an increase in the absolute number of medical bankruptcies, then it logically must follow that over the past two years the absolute number of medical bankruptcies has been cut in half. Alternatively, and more plausibly, the authors' conclusions about the number of medical bankruptcies were simply erroneous in the first place.

Medical Insurance and Bankruptcy

Lack of health insurance also can theoretically contribute to bankruptcy filings. If a family lacks health insurance, a catastrophic or long-term illness can deplete family savings and overwhelm the household with debt. As a result, a lack of health insurance may exacerbate the other difficulties created by health problems, such as increased debt and reduced income. In fact, however, there is no evidence that lack of medical insurance is a major causal factor in bankruptcy filings. Empirical research also finds little relationship between lack of health insurance and bankruptcy. Gross and Souleles found that a lack of health insurance was not a statistically significant predictor of

[20] *Id.* at 170.

bankruptcy.[21] Economist Joanna Stavins similarly found "no notable difference" between the percentage of bankruptcy filers with health insurance and the percentage of the non-filers with health insurance.[22] Himmelstein et al., find that "medical debtors were no less likely than other debtors to have [health insurance] coverage at the time of filing."[23]

Moreover, there are no macroeconomic trends in health insurance coverage that would suggest that lack of health insurance could be a major contributing cause to bankruptcy filings. Although the percentage of Americans without health insurance has risen gradually over time, this decline in coverage is the result of declining rates of health-care coverage among immigrants. The percentage of native-born Americans with health insurance has actually *risen* slightly since the official records began in 1993. The percentage of immigrants with health insurance, by contrast, has fallen during this period, especially among noncitizens.

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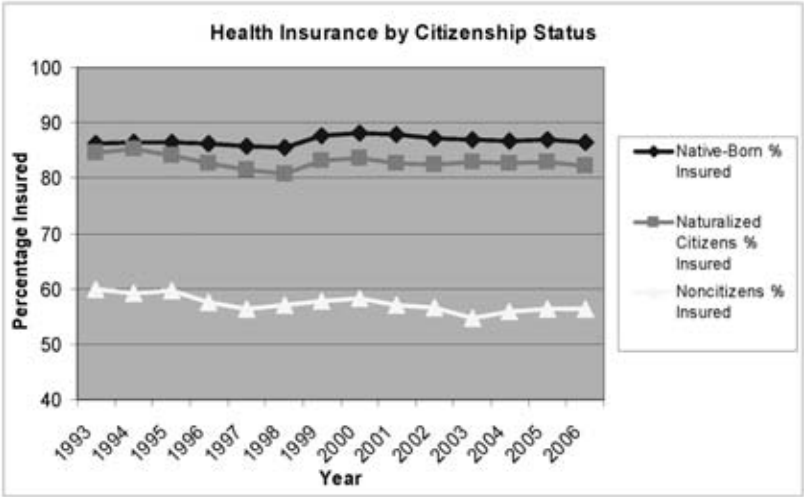
[21] David B. Gross & Nicholas S. Souleles, *An Empirical Analysis of Personal Bankruptcy and Delinquency*, 15 REV. FIN. STUD. 319, 334–35, tbl.2 (2002). Although they did not find lack of health insurance to be a predictor of bankruptcy, they did find it to be a predictor of credit card default.

[22] Joanna Stavins, *Credit Card Borrowing, Delinquency, and Personal Bankruptcy*, NEW ENG. ECON. REV., July/Aug. 2000, at 15, 22. In fact, Stavins found that those who filed bankruptcy in the past were *more* likely to have health insurance than those who did not, although they may have acquired health insurance after the filing. *Id.* at 25. Although it is unlikely that bankruptcy filers are more likely to be insured than non-filers, Stavins's findings certainly cast doubt on the claim that they are substantially more likely to lack insurance.

[23] Himmelstein et al., at W5-66.



Source: Center for Medicare Studies.

I have seen no reason to believe that the rise in medical bankruptcies has occurred only among immigrant groups and not among native-born Americans, suggesting that the absence of health insurance does not appear to be a substantial cause of medical bankruptcies. While this may raise other public policy concerns, it suggests that lack of health insurance is not likely to be causing a rise in medical bankruptcies.

WHAT TO DO ABOUT MEDICAL BANKRUPTCIES?

Leaving aside the factual question regarding the number of "medical bankruptcies" there still remains the policy question of what should be done about it.

Medical problems and bankruptcy present a difficult policy decision in that those on both sides of the transaction are generally innocent parties. One can certainly sympathize with a bankruptcy debtor who has been forced to file bankruptcy because a

serious medical problem has either resulted in the loss of his job or major medical bills. And this is precisely the sort of person for whom bankruptcy is intended and for whom the fresh start is particularly important.

On the other hand, a doctor who performs the service of delivering a healthy baby or a surgeon who saves someone after a heart attack certainly seems entitled to be paid for his or her services. When a debtor discharges medical debt, those losses must be passed on somewhere in the system, either through higher costs for insurers and other patients or reduced medical services. $100,000 in discharged medical debt may make the difference as to whether a hospital can hire an additional nurse for a year or provide free care to indigent patients. It is wholly right and appropriate to allow an innocent debtor a fresh start to recover from medical problems and medical bills; nonetheless, we should recognize that there are also conscientious health providers and other patients who eventually have to foot the bill for this opportunity. For every innocent debtor there is also an innocent creditor who provided those services.

Current bankruptcy law strikes an appropriate balance between these competing claims of innocent debtors and innocent providers of health care services. Medical debt typically is unsecured debt. Under current bankruptcy law, any unsecured debt incurred prepetition is treated the same as any other unsecured debt. In particular, under BAPCPA, medical debts are subjected to means-testing as with other unsecured debts. Thus, for instance, if a debtor paid for some of his or her health care by incurring credit card debt, that too would be dischargeable and subject to means-testing.

Under the means-testing provisions of BAPCPA, a debtor who earns above the state median income is expected to pay what he or she can in a Chapter 13 plan as a

condition for filing bankruptcy. A debtor who earns below the state median income, such as a debtor who is incapacitated and unable to work because of health problems, can file chapter 7 bankruptcy and receive a discharge of her debts. By contrast a debtor who has fully recovered and is able to work, but nonetheless has substantial medical bills, is required to repay as much as she can, whether 40%, 60%, or 80% in a chapter 13 repayment plan.

As this body recognized two years ago in a bipartisan vote with 70% overall support, this is a perfectly appropriate and reasonable balancing of the claims of debtors in financial distress and the legitimate claims of doctors to be paid for the valuable, and even life-saving, services that they provide.

Moreover, post-petition medical expenses are given special treatment under the means-testing provisions of BAPCPA. In determining the debtor's monthly expenses for purposes of applying the means-testing provisions of §707(b), the Code specifically subtracts from the debtors income expenses "reasonably necessary" for health insurance, disability, insurance and health savings accounts expenses for the debtor, the spouse of the debtor, or the dependents of the debtor. §707(b)(2)(A)(ii)(I). The debtor's monthly expenses may also include actual expenses paid by the debtor for reasonable and necessary expenses incurred for care and support of an elderly, chronically ill, or disabled household member of member of the debtor's immediate family. §707(b)(2)(A)(ii)(II). Finally, under §707(b)(2)(B), the debtor may rebut the means-test's presumption of abuse by demonstrating special circumstances such as a "serious medical condition" to the extent that such special circumstances justify additional expenses or adjustments of current monthly income.

On the other hand, given the efficacy of BAPCPA in weeding out fraud and abuse in the bankruptcy system, it could very well be that the percentage of bankruptcy cases today that are attributable to medical problems may be higher in the past. As noted, BAPCPA has cut bankruptcy filings in half, primarily by deterring fraudulent and abusive filings while preserving bankruptcy relief for those who need it, such as those with true medical hardship and overwhelming medical debt. If this deterrence of fraudulent filings has resulted in an increased percentage of medical bankruptcies as a statistical matter, then it would be expected that the percentage of injured and sick debtors would rise, but because of a reduction in the denominator (cases filed), not an increase in the numerator.

In short, the Bankruptcy Code today is well-equipped to deal with the challenges of medical bankruptcies. It strikes an appropriate balance between the needs of injured debtors and innocent creditors. Debtors today, including debtors with medical debts, are gaining the relief that they need while at the same time repaying what they can to doctors and medical providers who have offered them necessary and life-saving medical services.

CONCLUSION

Perhaps some here think that medical care is too expensive these days. I express no opinion on whether that is the case or if so what should be done to address the problem. It does seem obvious however, that bankruptcy law is *not* the appropriate place to try to deal with the problem of an overly expensive health-care system. Bankruptcy law should be concerned with striking an appropriate balance between debtors and creditors, including those in the health care system. Current law accommodates these concerns well and there is no need for further consideration at this time.

Chairman CONYERS. [Presiding.] Well, thank you for your testimony, sir.

Director Clifford White is the next witness. He oversees bankruptcy matters in the Federal court and supervises the means tests that are administered as part of that process.

Welcome to the Committee, sir.

TESTIMONY OF CLIFFORD J. WHITE, III, DIRECTOR, EXECUTIVE OFFICE FOR U.S. TRUSTEES, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Mr. WHITE. Thank you, sir. Chairman Conyers and Members of the Subcommittee, I appreciate the chance to be here today to discuss the role that medical expenses play in consumer bankruptcy filings.

The U.S. trustee program is that component of the Justice Department with the mission to enhance the integrity and the efficiency of the bankruptcy system. And our responsibilities range from consumer bankruptcy cases to reorganizations of large corporations.

I would like to address three aspects of the topic of the hearing this afternoon. First, as the Chairman mentioned, one of the most significant changes made in the bankruptcy reform law was the establishment of a means test. And under the means test, individual debtors with income above their State's median income level are allowed to deduct expenditures set forth in the statute. Most medical expenditures may be deducted.

If the debtor has income above allowed expenses, the debtor may be presumed abusive and the case subject to a motion to dismiss by the U.S. trustee. A debtor may rebut that presumption by demonstrating special circumstances such as a serious medical condition.

As of June 30, 2007, about 8 percent of debtors who filed Chapter 7 petitions after enactment of the means test had income above the State median income level and thus were subject to the full means test. Of those debtors, approximately 12 percent were presumed abusive. But the U.S. trustee declined to file a motion to dismiss in about 22 percent of those presumed abuse cases. And the reason for about one out of every five of those declinations was high medical expenses or loss of income from illness or injury.

So Congress established an objective system for determining eligibility but also resided in the U.S. trustee discretion to decide whether to seek dismissal, whether a dismissal would be appropriate. Accordingly, debtors who have incurred high medical debt or anticipate significant future medical expenditures or who have lost income due to medical conditions may be entitled to Chapter 7 relief irrespective of the means test formula.

My second point is that the U.S. trustee program does not have definitive data on the amount of medical debt owed by consumer debtors who seek bankruptcy relief. In 2003, however, we did review a sample of 5,000 cases utilizing data from official records of Chapter 7 cases closed between the years 2000 and 2002.

In general, those data revealed that about 5 percent of total general unsecured debt was medical related. Forty-six percent of the

debtors listed medical debt. Of those debtors who listed medical debt, about 80 percent reported medical debt of less than $5,000.

Fewer than 1 percent of the cases accounted for more than a third of the medical debt. And less than one out of 10 cases, about 10 percent of the cases, represented about 80 percent of total reported medical debt. Now, for the most part, this accounting would not have identified medical debts that were charged on credit cards, placed with collection agencies or paid prior to a bankruptcy filing.

Third and finally, the need for bankruptcy data that is readily accessible was recognized by the Congress in Section 604 of the reform law, which provides that the bankruptcy court should make data publicly available in an electronic format. This presumably would include financial information contained in schedules, statements, and other documents filed by debtors in bankruptcy court.

Although medical debt is difficult to identify with precision on the current official forms, there may be ways that such data can be made more accessible for policy makers, for administrators, and researchers. The U.S. trustee program, for example, has been working with the administrative office of U.S. courts and the Judicial Conference of the United States on an automation solution which entails the tagging of data on bankruptcy forms. The resulting data-enabled, or so-called smart forms, among other things, would allow a computer system to automatically aggregate and simplify review of data.

Data-enabled technology would allow researchers and others to more easily identify cases with high medical expenses and other features. In addition, much of the means tests which we perform could be done through data tagging allowing the program to perform its duties more effectively and allowing debtors to know earlier in the process whether the program will deem their case to be presumed abusive.

The courts adopted a jointly developed technical standard for data tags about 2 years ago but has postponed their widespread use pending further study. If the courts ultimately adopt this new technology as a mandatory standard, then bankruptcy administration will be streamlined and policy makers will have more information to evaluate the effectiveness of the system.

In sum, the U.S. trustee program is committed to improving consumer bankruptcy case administration for the benefit of debtors, creditors, and the public. And this will include the exercise of appropriate discretion in evaluating bankruptcy cases that exhibit substantial medical debt.

I would be happy to answer any questions from the Subcommittee. Thank you.

[The prepared statement of Mr. White follows:]

PREPARED STATEMENT OF CLIFFORD J. WHITE III

Department of Justice

STATEMENT

OF

CLIFFORD J. WHITE III
DIRECTOR
EXECUTIVE OFFICE FOR UNITED STATES TRUSTEES
U.S. DEPARTMENT OF JUSTICE

COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW
UNITED STATES HOUSE OF REPRESENTATIVES

"HEARING ON WORKING FAMILIES IN FINANCIAL CRISIS: MEDICAL DEBT AND BANKRUPTCY"

PRESENTED ON

JULY 17, 2007

Statement of

Clifford J. White III
Director
Executive Office for United States Trustees

"Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy"

Committee on the Judiciary
Subcommittee on Commercial and Administrative Law
United States House of Representatives

July 17, 2007

Madam Chairman and Members of the Subcommittee,

Thank you for the opportunity to appear before you to discuss the role that medical expenses play in consumer bankruptcy filings. The United States Trustee Program (USTP or Program) is the component of the United States Department of Justice with the mission to enhance the integrity and efficiency of the bankruptcy system.[1] The Program's responsibilities include consumer bankruptcy cases and reorganizations of large corporations that seek chapter 11 relief. As the primary enforcer of many of the key consumer provisions of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA), each of the Program's 95 field offices, and the private trustees whom we appoint and supervise, are called upon to review individual debtors' financial circumstances and to determine whether the bankruptcy relief sought is appropriate or an impermissible abuse of the bankruptcy system.

[1] The USTP has jurisdiction in all judicial districts except those in Alabama and North Carolina. The duties of the USTP are set forth in titles 11 and 28 of the United States Code. In addition to specific statutory duties and responsibilities, United States Trustees "may raise and may appear and be heard on any issue in any case or proceeding under this title but may not file a plan pursuant to section 1121(c) of this title." 11 U.S.C. § 307.

Most consumers seeking bankruptcy protection file under either chapter 7 or chapter 13 of the Bankruptcy Code. Chapter 7 provides for the liquidation of a debtor's nonexempt property and the distribution of the proceeds to creditors. In more than 9 out of 10 chapter 7 cases, all of the debtor's assets are exempt. Chapter 13 provides for repayment of all or part of the debts over a three to five year period, but the debtor retains all of his or her assets. Under both chapters, debtors receive a discharge of most kinds of unsecured debt.

Under the new section 707(b) of the Bankruptcy Code, Congress imposed a more objective and transparent test to determine eligibility for relief. Individual debtors who file under chapter 7 are now subject to a "means test" to determine their disposable income. Debtors with income above their state's median income level are allowed to deduct expenditures set forth in the statute. If the resulting disposable income is more than $110 per month, the debtor may be "presumed abusive" and the case subject to dismissal. In determining allowable expenses, the BAPCPA mandated the use of standards developed by the Internal Revenue Service (IRS) for certain expenses. The IRS standards also are used to provide the framework for determining the amount of disposable income that a debtor would be required to pay to unsecured creditors in a repayment plan.[2/]

[2/] Based upon data compiled for a report to Congress from the Director of the Executive Office for United States Trustees on the impact of the IRS Standards, as required under section 103(b)(1) of the BAPCPA, the USTP found that the IRS standards allow above median chapter 13 debtors to deduct an average of $490 in expenses more than the amount that debtors report they actually spend. As income rises, the differential becomes smaller. This means that the IRS standards have a progressive impact on above median debtors, such that those with lower incomes are treated more favorably than those with higher incomes. The USTP's report is based upon data collection and analysis performed under contract by the RAND Corporation.

Within ten days after a statutorily required meeting where creditors, private trustees, and the United States Trustee may question a debtor under oath, the United States Trustee must determine if a case is "presumed abusive." Within thirty days thereafter, the United States Trustee must file a motion to dismiss the case or a statement explaining why a motion would not be appropriate to file. 11 U.S.C. § 704(b). A debtor may rebut a presumption of abuse "by demonstrating special circumstances, such as a serious medical condition," to the extent such special circumstances justify additional expenses or adjustments of current monthly income "for which there is no reasonable alternative." 11 U.S.C. § 707(b)(2)(B)(i).

From October 17, 2005, to June 30, 2007, approximately eight percent of debtors who filed chapter 7 petitions had income above the state median income. Of those debtors, approximately 12 percent were "presumed abusive." The United States Trustees declined to file a motion to dismiss in approximately 22 percent of those cases.[3/] The reason for almost one out of every five declinations was high medical expenses or loss of income from illness or injury. To provide just one example, a United States Trustee declined to seek dismissal of a case involving married debtors where the wife suffered from degenerative epilepsy that rendered her unable to work and required her husband to reduce his work hours to provide care for her. Given the progressive nature of the wife's condition, the United States Trustee determined that it was

[3/] United States Trustees are now filing motions to dismiss chapter 7 cases at about twice the rate as were filed prior to enactment of the BAPCPA (i.e., about eight motions to dismiss per 1,000 cases versus about four motions to dismiss per 1,000 cases pre-BAPCPA). These numbers include motions brought in "presumed abusive" cases under section 707(b)(2), as well as motions brought under the "totality of the circumstances" standard established under section 707(b)(3).

unlikely that the husband would earn income at the same level he did prior to their bankruptcy filing.

The Program believes strongly that the Congress established an objective system for determining eligibility, but also resided discretion in the United States Trustee to decide whether dismissal would be "appropriate." Accordingly, debtors who have incurred high medical debt or anticipate recurring significant medical expenditures may be entitled to chapter 7 relief irrespective of the "means test" formula.

The USTP does not have definitive data on the amount of medical debt owed by consumer debtors who seek bankruptcy relief. In 2003, the Program reviewed a sample of more than 5,000 bankruptcy cases utilizing data from official records in no-asset chapter 7 cases closed between 2000 and 2002. In general, the data describing medical-related expenses contained in official documents filed by chapter 7 debtors revealed that slightly more than five percent of their general unsecured debt was medical related. Forty-six percent of the debtors listed medical debt. Of those debtors listing medical debt, about 78 percent reported medical debt of less than $5,000. Fewer than one percent of the cases accounted for over one-third of the medical debt. Less than 10 percent of the cases represented about 80 percent of all reported medical debt. For the most part, this accounting would not have identified medical debts charged on credit cards, placed with collection agencies, or paid prior to a bankruptcy filing.

The need for bankruptcy data that is readily accessible was recognized by Congress in section 604 of the BAPCPA which provides, in pertinent part, that "the national policy of the

United States should be that all data held by bankruptcy clerks in electronic form . . . should be released in a usable electronic form in bulk to the public, subject to such appropriate privacy concerns . . . ." Debtors' financial information is contained in schedules, statements, and other forms filed by debtors in the bankruptcy court. Although medical debt is difficult to identify with precision on the current official bankruptcy forms, there may be ways that such data can be made more accessible for policymakers, bankruptcy administrators, and researchers.

The USTP has been working with the Administrative Office of the United States Courts and the Judicial Conference of the United States on a new automation solution which entails the "tagging" of data on bankruptcy forms. "Data-enabled" or "smart" forms, among other things, would allow a computer system automatically to route filings into identified categories and to simplify the review of data. With appropriate changes to bankruptcy forms, data-enabled form technology would allow researchers and others to more easily identify cases with high medical expenses, domestic supports orders, or other features. In addition, much of the "means test" could be performed through data tagging, thereby allowing the USTP to perform its duties more effectively and allowing debtors to know sooner in the process whether the USTP will deem their case to be "presumed abusive." The Administrative Office adopted the jointly developed data-enabled technical standard approximately two years ago, but postponed its widespread use pending further study. If the Judicial Conference ultimately grants the USTP's request for the adoption of data-enabled forms as a mandatory standard (with appropriate exceptions), then bankruptcy administration will be streamlined and policymakers will have more information to evaluate the effectiveness of the bankruptcy system.

The USTP is committed to improving consumer bankruptcy administration for the benefit of debtors, creditors, and the general public. This includes the exercise of appropriate discretion in evaluating bankruptcy cases that exhibit substantial medical debt.

I would be happy to answer any questions from the Subcommittee.

Chairman CONYERS. Thank you very much.

Well, we have had Donna Smith already. We now go to Professor Elizabeth Warren of Harvard.

We are so glad to have you here. And you may proceed with your testimony.

TESTIMONY OF ELIZABETH WARREN, HARVARD LAW SCHOOL, CAMBRIDGE, MA

Ms. WARREN. Thank you. And thank you, Congressman Conyers, for inviting me here to talk today about an important problem facing hard-working Americans.

No family wants to file for bankruptcy. Bankruptcy is an unmistakable sign of failure. It is an indelible mark that will be remembered long after the creditors have moved on and the court records have been archived.

It is costly financially and also often costs families their dignity. Moreover, it doesn't solve the problem. As Ms. Smith pointed out, the medical bills can still stack up post-bankruptcy. And yet Congress in its wisdom has decided to lengthen the time before a family can file for bankruptcy a second time.

For a family facing bankruptcy in the aftermath of a medical problem, the pill is especially bitter. Whether the problem was one of chronic disease or sudden accident, the typical family is already exhausted when it tries to cope with unpaid bills, indecipherable charges, a maze of insurance payments and denials, and time lost from work. Financial problems piled on top of health problems can be overwhelming.

For too many hard-working middle class families, a single diagnosis or accident can mean financial ruin. Even a relatively routine problem such as an appendectomy or long-term care from diabetes can be enough to over-stretch a family budget. I will focus today on data that my coauthors and I have developed about families that file for bankruptcy and briefly note several other studies that have similar sorts of results.

But I want you to keep one thing in mind. When we look at bankruptcy, we are looking at the tip of a very large iceberg. Economists estimate that for every family that goes into bankruptcy, there are another 16 families who would benefit financially from filing if only they were willing to do so. How many more families are struggling beyond that? We are getting a peek at different pieces of the data. And I will try to mention some of those near the end.

So let us start with the numbers. About half of all the families filing for bankruptcy do so in the aftermath of a serious medical problem. Here is the breakdown.

We start with families' own description. That is we ask the families, and they tell us. Forty-six percent of the families filing for bankruptcy tell us, as Ms. Smith did, that medical problems were at least a part of what drove them into bankruptcy. That is the first, the pale blue, bar on the figure on the chart on the left.

We also looked at the financial impact of medical problems from other perspectives. We saw there that about one in five debtors, 21 percent of the debtors from the core sample, indicated that they had lost at least 2 weeks of income because of a medical problem.

Sometimes it was the worker who was ill or injured. Sometimes it was parents who had to lose time to deal with children who were ill or with elderly parents of their own.

Some filers mortgaged their homes in order to pay off medical debts, 2 percent of the total sample, about 4 percent of all of the home owners. There are many overlaps among the categories, but the bottom line is the dark blue bar on the right. If we count those categories together, self-report, mortgaging a home to pay for medical bills, and missing at least 2 weeks worth of work, we end up with 56 percent of the families in bankruptcy in the aftermath of a serious medical problem.

Now, we could take even more perspectives on this. Two percent of the sample identified that alcohol and drug problems were a reason for filing. For parents who explained that they had bankrupted themselves putting teenage children through substance abuse rehabilitation programs, this would seem to be an appropriate inclusion.

One percent of the families identified a family member's gambling problem as a reason for filing. Recognizing that families get left behind financially when a spouse or parent goes on a gambling binge, loses the house, and leaves everyone deep in debt. Twenty-six percent of the core sample reported having unpaid medical bills at the time of their filing in excess of $1,000. The median debt was over $11,000, very close to Ms. Smith's $1,000 a month.

If we included this measure, then the proportion of families filing for bankruptcy would rise from about half to about two-thirds. Different people may have different opinions on whether to include them. I am simply trying to get all of the data out there.

I should point out that our data are not inconsistent with other studies. For example, a study that may be particularly interesting to Congressman Cannon, a new study from Utah reported just 2 weeks ago reports that 61 percent of families file bankruptcy in the aftermath of serious medical problems. That follows-up on an earlier Utah study showing that 60 percent of the families were in bankruptcy following serious medical problems, an especially poignant point in Utah, since Utah has one of the highest bankruptcy filing rates in the country.

A Delaware study concludes that based on court record data alone that large medical bills led to a 50 percent increase in the likelihood of filing for bankruptcy. An Illinois study shows that 58 percent of bankruptcy filings involved medical debt. Researchers specifically noted this number does not include medical debt that was paid with credit cards or by borrowing from a loan company.

An upstate New York study found 58 percent of the families in bankruptcy were dealing with medical debt. Some of the research has focused on particular illnesses. For example, those with cancer indicate that their bankruptcy filing rate is about 3 percent, much higher than the national average.

I just want to point out a little larger context and then I will stop. And that is the data in bankruptcy are there because of the data in the population generally. I just pick a few.

Seventy-seven million Americans aged 19 and older, that is two out of every five adults, 37 percent of the population, report that they have difficulty paying medical bills and have accrued medical

bills they cannot pay. Twenty-one percent of non-elderly adults have been contacted by a collection agency over a medical bill within the past 12 months. Forty-four percent of medical debtors had credit card debts higher than $10,000.

Forty-six percent of those in a Baltimore study report currently owing money from medical debts they cannot pay. Forcing families into bankruptcy is not an answer.

Just last week, Bill Novelli, the CEO of AARP, cited a Gallop survey across the country in which he noted that almost half of all Americans are worried about paying medical costs if they become seriously ill or have an accident. Mr. Novelli urges the millions of AARP members to make health care reform their number one issue in the 2008 elections.

Like Ms. Smith, I ask Congress to act to protect American families from the financial fallout of our current health care system.

[The prepared statement of Ms. Warren follows:]

PREPARED STATEMENT OF ELIZABETH WARREN

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Medical Bankruptcy: Middle Class Families at Risk

by

Elizabeth Warren
Leo Gottlieb Professor of Law
Harvard Law School

Testimony Before
House Judiciary Committee
July 17, 2007

Professor Warren has not received any Federal government grants or contracts relevant to the subject matter of this testimony.

Introduction

No family wants to file for bankruptcy. Bankruptcy is an unmistakable sign of failure; an indelible mark that will be remembered long after the creditors have moved on and the court records have been archived.

For a family facing bankruptcy in the aftermath of a medical problem, the pill is especially bitter. Whether the problem was one of chronic disease or sudden accident, the typical family is already exhausted when it tries to cope with unpaid bills, indecipherable charges, a maze of insurance payments and denials, and time lost from work. Financial problems piled on top of health problems can be overwhelming.

For too many hard-working middle class families, a single diagnosis or accident can mean financial ruin. Even a relatively routine problem such as an appendectomy or the long-term care of diabetes can over-stretch a family's budget. Today, I will focus on data developed by my coauthors[1] and myself that document the difficulties facing these families. I will also briefly note other studies with different designs and different populations, taken over somewhat different time periods. These studies reveal similar problems.

Together, the work of many researchers strongly suggests that America is facing a crisis in health care. The current system for paying for medical care is bankrupting hard-working, middle class families. Since 2000, an estimated five million families have filed for bankruptcy in the aftermath of serious medical problems.[2] According to economists, for every family filing for bankruptcy, another sixteen families are in serious enough financial trouble that they would benefit from bankruptcy if only they were more willing to file.[3] The current health care finance system is bankrupting hard-working, play-by-the-rules American families.

The families that file for bankruptcy not concentrated among the chronically poor. Instead, they are people who have been to college, who have gotten decent jobs, and who have bought homes and started families.[4] Most are wage-earners, although about one is seven has started a small business.[5] In other words, when measured by the most enduring criteria, they are our neighbors and friends, a sample of middle class and working class America. Right up until the bills piled up or the time lost from work left them unable to cover basic expenses, most of these families never dreamed they would end up in a bankruptcy court.

Filing for Bankruptcy in the Aftermath of Medical Problems[6]

About half of all families filing for bankruptcy do so in the aftermath of a serious medical problem.[7] This was the conclusion of Drs. Himmelstein, Thorne, Woolhandler and myself in a scholarly article published in *Health Affairs*.[8] We reported on the concept of a medical bankruptcy—that is, a bankruptcy filing that was significantly influenced by

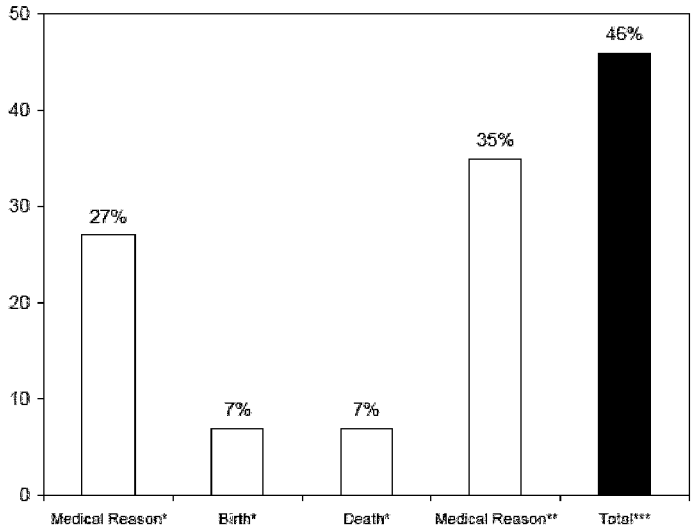
the medical problems facing someone in the family. The research for that article, as well as for subsequent work by Professor Melissa Jacoby and myself, was grounded in the 2001 Consumer Bankruptcy Project. Details of that study are available in several publications.[9] I am here today to provide more analysis of those data and to summarize other studies of the relationship between getting sick and going broke.

The research method for the Consumer Bankruptcy Project relies heavily on self-reporting by debtors through written questionnaires and extended follow-up telephone surveys. It is possible that debtors perceive the role of medical problems differently from an omniscient observer. Some might overstate the role of ill health, believing it to be a more acceptable explanation than, for example, overspending.[10] Overstating is more difficult in the context of highly detailed questions over a period of time, as in the telephone surveys, but nonetheless is possible.[11] Of course, the role of medical problems may be understated in other respects. Some filers did not finish the written questionnaire and thus did not respond at all to the last question that asked them to indicate reasons for their bankruptcy filings; we count them as not having a medical reason for filing on the basis of their non-response, although in reality we do not know that to be the case.[12] In addition, some debtors did not characterize their problems as medical-related even when health difficulties set their problems into motion. For example, some explained their bankruptcy filings as attempts to save their homes from foreclosure; only later, in detailed questioning, would it emerge that the now-defaulted mortgage had been taken out to pay big medical bills. Others attributed financial downfall to large credit card debts or time off from work, obscuring what others might have considered medical reasons. In addition, debtors who participated in the telephone survey had a disincentive to report medical-related financial problems. Any respondent who said that medical problems did not play a role in their bankruptcies was not required to sit through another half an hour's worth of probing and sometimes embarrassing questions.[13]

For these and other reasons, it is challenging to determine which debtors can be said to have "medical bankruptcies."[14] We recognize that different researchers might make different judgment calls about which debtors should be included in this category and which should not. To make the data as useful as possible for the Congress and for other readers and policymakers, various breakdowns of the data are offered here.

In the written survey, about 27% of the debtors from the core sample indicated illness or injury as a reason for filing bankruptcy, 7% identified the birth of a child as a reason for filing bankruptcy, and another 7% explained that a death in the family -- which studies in the past have interpreted to have a medical component -- precipitated their filings.[15] Among those from the core sample who also took the telephone survey, about 35% of the debtors indicated that illness or injury of self or family member, addition of a family member, or death of a family member as a reason for their bankruptcy filings.[16] Debtors were asked a similar question in the telephone survey. When responses from the written questionnaires are combined with the telephone surveys, about 46% self-identified a medical reason of some kind (birth, death, illness, or injury) among their reasons for filing bankruptcy.[17]

Figure 1: Debtors Identify Medical Reasons Behind Bankruptcy Filing

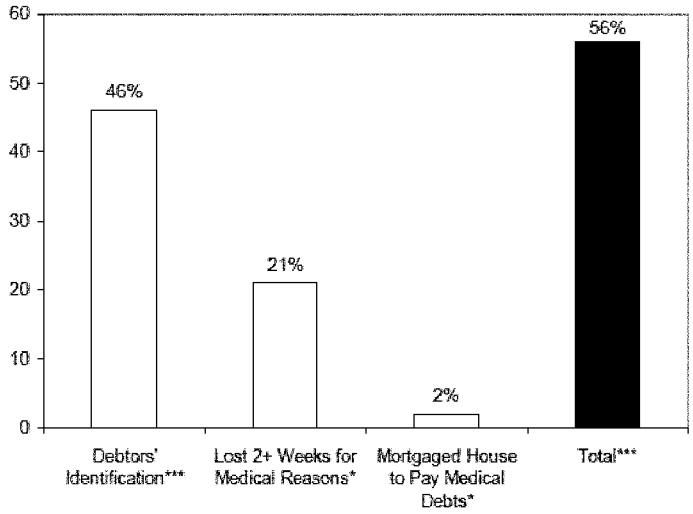


*Source: 2001 Consumer Bankruptcy Project (*Written Questionnaire, N = 1250; **Phone Survey, N = 602; ***Phone/Written Combined, N = 602)*

Our study collected other indications of medical-related financial distress whether or not the debtor self-identified medical reasons for filing. In the written questionnaire, about one in five debtors (21%) from the core sample indicated that they had lost at least two weeks' income because of a medical problem.[18] For some, the primary wage earner was ill, and for others, it was a child, spouse or elderly relative who required care. Either way, we surmised that the loss of at least two weeks' income constituted a hard financial blow for families with modest incomes.

Some filers mortgaged their homes in order to pay off medical debts. The numbers were modest—2% of the total sample, about 4% of the homeowners surveyed—but the impact on the family finances could be quite serious.[19] Many of those who mortgaged their homes or lost time from work self-identified as filing for bankruptcy at least in part because of medical problems. But some did not. Combining the data from self-identifiers, as depicted in Figure 1, with these other filers increases the total percentage of medical-related filers to 56%.

Figure 2: Medical Reasons Plus Medical-Related Job Loss and Mortgages

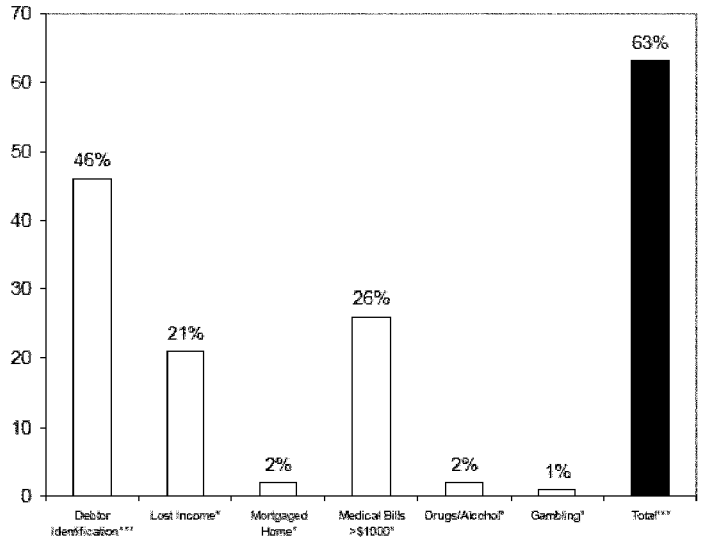


Source: 2001 Consumer Bankruptcy Project
*(*Written Questionnaire, N = 1250; ***Phone/Written Combined, N = 602)*

Other responses from filers also produce inferences of medical-related financial problems. For example, some researchers may want to include the 2% of the sample that identified alcohol and drug problems as a reason for filing.[20] For parents who explained that that they had bankrupted themselves putting their teenaged children through substance abuse rehabilitation programs, this would seem to be an appropriate inclusion. Similarly, other researchers would want to include the 1% of the sample who identified a family member's gambling problem as a reason for filing, recognizing that some families get left behind financially when a spouse or parent goes on a gambling binge, loses the house, and leaves everyone deep in debt. In addition, about a quarter (26%) of the debtors in the core sample reported having medical bills in excess of $1,000 that were not covered by insurance in the two years before filing.[21]

Not all researchers would agree with a decision to include filers from these three categories in counting medical-related filings if the respondents did not also offer other indications of medical-related bankruptcy filings, as reported in Figure 2. To make the data as accessible as possible, we present our report both ways. If we exclude these three measures, the proportion of families filing for bankruptcy in the aftermath of a medical problem is 56%; if they are included, the number climbs to 63%.

Figure 3: Medical-Related Bankruptcy - All Sources



Source: 2001 Consumer Bankruptcy Project
*(*Written Questionnaire, N = 1250; ***Phone/Written Combined, N = 602)*

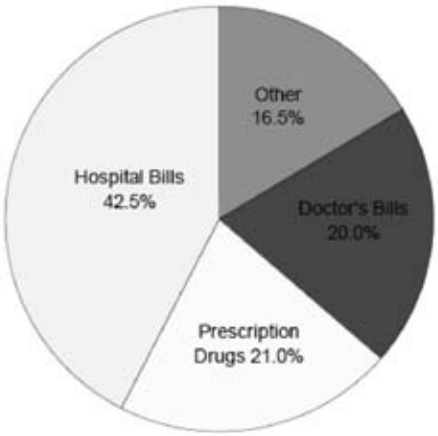
By any analysis, this study documents that a substantial number of families file for bankruptcy in part to deal with the fallout from medical problems. If the proportions we observed in the 2001 Consumer Bankruptcy Project were representative of bankruptcy filers nationwide, this would mean that an estimated 668,000 to 915,000 families filed for bankruptcy in a single year, 2001, at least in part due to medical-related financial distress.[22] These numbers pale in comparison with the debtors who have similar problems but who stay out of bankruptcy.[23] By any analysis, the indication of widespread economic stress is unmistakable.

Sources for Medical-Related Indebtedness

No doubt, hospital bills can be burdensome financially. Among a subset of the telephone survey medical sample who indicated that they incurred a significant medical debt, 42.5% identified hospital bills as the single biggest expense,[24] and some of these people might fit the profile of the patients featured in the news media. The role of hospital bills must be kept in perspective, however. If 42.5% of these filers identified

hospital bills as their single biggest expense, there would still be nearly 60% whose biggest expenses were something other than a hospital bill. For example, as shown in Figure 4 below, about one fifth (21%) identified prescription drugs as their biggest expense.[25] One fifth (20%) identified doctor bills as their biggest expense.[26]

Figure 4: Largest Bills Not Covered by Insurance Among Filers with Significant Medical Expenses



Source: 2001 Consumer Bankruptcy Project (Phone Survey, Valid N = 196)

27

The fact that hospital bills are one of many type of significant medical expense for individuals of modest means should not be surprising. For example, consumer's out-of-pocket payments to hospitals are a tiny fraction of overall out-of-pocket payments in the United States.[28] Doctor visits far exceed hospital visits.[29] Studies in the medical literature have emphasized the role of non-hospital medical expenses when they evaluate cost-related under-use of health services and drugs.[30] In one recent study, the overwhelming majority of older Americans in the study reported no out-of-pocket expenses for hospital or nursing home care, but most had other kinds of out-of-pocket medical expenses.[31]

Many families turn medical bills into ordinary consumer credit. About three in ten (29.3%) of cases from the telephone survey medical sample reported use of credit cards for medical expenses.[32] Although the data are not sufficiently detailed to determine whether the bills were big or small, paid off quickly or strung out over time,[33] this percentage suggests that a substantial portion of the debt listed in bankruptcy may appear

to be for ordinary consumption when, in fact, it is for medical services that were paid with ordinary credit.

Some families go into debt more deeply to try to pay medical bills. About 2% of all homeowners in the written questionnaire sample mortgaged their homes to pay medical bills.[34] Among homeowners who had taken second or third mortgages on their homes, 15% had taken this step to finance their medical expenses.[35] In the telephone survey medical sample, 13.8% of bankrupt homeowners with high cost mortgages cited a medical reason for the loan.[36] They have taken a trip through bankruptcy and may owe nothing directly to a health care provider, but these debtors will lose their homes if they do not repay this medical-related mortgage debt in full.

Bankruptcy filers are not alone in their use of consumer credit for medical expenses. Nationally representative studies have found families using personal loans, credit cards, and mortgages to finance medical bills.[37] According to Visa, patients charged $19.5 billion in health care services to Visa cards in 2001, which was made possible by the fact that most medical practices now accept credit cards.[38] A study by Demos reported that 29% of low and middle income households with credit card balances reported that medical expenses contributed to their current debt loads.[39]

In addition to the use of general purpose credit for medical care, medical providers may have unpublicized and informal relationships with lenders to provide credit to their patients to finance their care.[40] Further, lenders offer medical-specific products. Examples of medical-specific credit products and receivables arrangements with providers include the Citi® Health Card,[41] CareCredit (a division of GE Retail Sales Finance),[42] AccessOne,[43] MedCash,[44] Pxpert,[45] the King Thomason Group TotalCare Medical Accounts Receivable Credit Card Program,[46] the HELPcard,[47] MediCredit,[48] and HelpEZ.[49] The Federal Trade Commission has noted the existence of a "well-established market" for medical-specific loans.[50]

Studies that focus solely on court records fail to capture the information from the debtors about the source of the purchases that have resulted in high credit card bills or second mortgages. As such, these studies substantially understate the actual impact of medical costs on families.

Income and Medical Debts

The bankruptcy data contain several indicia that medical-related indebtedness is not just a consequence of direct medical bills. For example, bankruptcy filers sometimes indicate illness or injury as a reason for filing even if they do not indicate personal liability for large medical bills.[51] As noted earlier, about one in five debtors (21%) from the core sample indicated that they had lost at least two weeks' income because of a medical problem.[52]

Among those who had identified a medical reason for filing in the telephone survey sample, four out of ten (40.1%) of the families said that medical debt was *not a factor at all* in their decision to file.[53] Half (50.8%) said that prescription drug costs were not a factor at all.[54] But slightly more than seven of ten (71.6%) reported that income loss due to health problems contributed "very much" to their bankruptcies and another 8.6% said income loss contributed "somewhat" to their bankruptcies."[55]

The long-term diagnoses of the filers reinforce the role that income loss may continue to play in their financial outlook. Slightly over half (51.7%) of the medical problems identified in the telephone survey sample involved ongoing chronic illnesses, some of which may continue to complicate earning capacity.[56] Although we cannot prove that the filers' health conditions made them disabled in accordance with applicable definitions, only 21.2% of the ill people employed at the time of illness onset in the telephone survey medical sample reported that their employer had offered them long-term disability insurance coverage,[57] and only about 15% of that same sample reported actually having some form of long-term disability insurance coverage.[58]

Complicating the role of income loss is the fact that the bankruptcy filers often were not themselves the ill or injured person but they lost income while taking care of sick relatives.[59] Of the medical bankruptcy filers who had curtailed paid employment as a result of a medical problem, more than half (52.8%) did so to take care of someone else.[60] In 13.3% of the medical bankruptcy cases involved in the follow-up telephone survey, primary earners were trying to take care of a sick child.[61] The filers tell stories of premature births and chronically ill or disabled children with constant care needs. Among those in the sample were parents who reported missing months of work when a child with spinal bifida required repeated operations, when a baby was born with heart defects, or when an infant with sickle cell anemia needed special care.[62] A parent faced substantial work disruptions because of an autistic child, and yet another lost income to deal with an epileptic child.[63] A child with severe bipolar and anxiety disorder required twenty-four hour monitoring, leading first to significant leaves of absence and eventually job loss for the child's mother.[64] After being told by doctors that their son with kidney problems would die, one set of parents moved the entire family to a different state with hopes of better treatment and a different prognosis.[65] Some bankruptcy filers reported caring for the children of their seriously ill siblings.[66]

Other filers reported losing income to care for spouses, aging parents, or other relatives. One man reported caring for his wife while she battled lung cancer, while another went back to work only after his wife had three operations in six months and finally was able to walk down the hallway of their home without his help.[67] An adult daughter struggled to help with her mother's medical bills not covered by Medicare and eventually took unpaid family leave so she could take her mother for medical treatments.[68] Adult children temporarily or permanently moved in with parents to help them cope with the effects of Alzheimer's disease or terminal illnesses.[69] One man cared for an uncle with cancer while trying to raise a toddler grandson and assist his son with college.[70]

The statistics and stories show another side of the health care debates. The financial impact of a serious medical problem can reverberate through a family in many ways. A comprehensive health care finance policy deals with both direct medical costs and the indirect costs of time lost from work.

Other Studies of Medical Bankruptcy

A number of other researchers have explored the connection between medical and financial problems. They point in a similar direction as the Consumer Bankruptcy Project.

Perhaps the closest study is a single district study out of Utah in 2004. Researchers Ezekial Johnson and James Wright studied 281 bankrupt families.[71] They discovered that 61% of families cite medical problems as a major reason for their financial troubles. They note the higher-than-average citation of medical reasons in Utah as possibly linked to the state's low expenditures on health care and the increased likelihood of no health insurance for Utah families. They compare these data with other states that have lower filing rates and better support for families with medical problems.

Johnson and Wright's study followed an earlier study of Utah families in bankruptcy conducted by the Salt Lake Tribune.[72] Researchers analyzed court records for 1,053 randomly selected bankrupt families from June 2003 to June 2004, and concluded that 60% of the families were in bankruptcy because of unpaid medical bills. A more recent study of Utah families by the United Way reached a similar conclusion.[73] This statewide telephone survey of nearly 2000 households plus focus group with 55 Utah citizens concluded that healthcare and job-related factors were most cited as affecting financial stability.

In another study of bankruptcy families, Ning Zhu studied 1,667 Chapter 7 cases and 1,089 Chapter 13 cases filed in 2003 in Delaware. This project used only court record data, so it could not provide a comprehensive look at the number of bankrupt families with medical problems. But the court record data alone showed that large medical bills led to a 50% increase in the likelihood of filing for bankruptcy.

In a study of 279 bankruptcy cases filed in Champaign County, Illinois in December 2001, 58% of the filings involved medical debt. Researchers Claudia Lenhoff and Brooke Anderson noted, "This number does not include medical debt that was paid for with credit cards or by borrowing from a loan company." Claudia Lenhoff and Brooke Anderson, Champaign County Health Care Consumers' Medical Billing Task Force, Medical Debt in Champaign County (April 2003).

A recent regional study of debtors filing for bankruptcy concentrated on low-income families. Trilby de Jung studied 348 families seeking help at bankruptcy clinics in Albany, Syracuse, Rochester and Buffalo, New York in 2005.[74] Among the

respondents, 58% had medical debts, and 36% experienced a loss of income associated with their medical problems.

Some researchers have focused on the financial impact of particular illnesses. A 2006 USA Today, Kaiser Family Foundation, and Harvard School of Public Health survey of households affected by cancer documented that 3% of these families had declared bankruptcy and 7% had taken a second mortgage on their homes.[75] In addition, 13% were contacted by a collection agency over their medical debts. One quarter of the families said they had used up all their savings dealing with the fallout from cancer, and one-tenth could not afford basics such as food, heat and housing.

Researchers Deanna L. Sharpe and Dana Lee Baker explored the financial impact of having a child with autism.[76] The authors cite several stories of uncovered health expenses and the families' increasing need to file bankruptcy.

In an American Enterprise Institute study, Aparna Mathur analyzed data from the Panel Survey of Income Dynamics, using longitudinal data to examine the relationship between medical problems and bankruptcy.[77] The PSID data focused on 74 families who admitted to filing for bankruptcy.[78] The dataset includes the debtor's explanations for why they filed for bankruptcy, but Mathur bypassed these data, examining only the reported reasons for incurring specific debts. Mathur concluded that medical debts were significantly related to bankruptcy filings, although they were often not the main reason for filing. Mathur sets the floor at 27% of bankruptcies as caused primarily by medical problems, while other debtor's medical problems, job problems and other difficulties are tangled together.

Other Studies of Economic Pressures Associated with Medical Problems

There are a number of studies that do not focus specifically on bankruptcy, but they draw the connection between medical and financial problems. In effect, these are the studies that show, at least in part, why so many families end up in medical bankruptcy. Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren conducted a national telephone survey in 2003-04 for the Commonwealth Fund.[79] They studied 4,052 households. Among the key findings:

- 77 million Americans age 19 and older—nearly two of five (37%) adults—have difficulty paying medical bills, have accrued medical debt or both within past three years.
- Working-age adults incur significantly higher rates of medical bills and debt problems than those 65 and older, highest rates among uninsured. Even those with health insurance have significant trouble.
- 2/3 of people with a medical bill or debt problem went without needed care because of cost—nearly three times the rate of those without these financial problems.

- 21% of all non-elderly adults have been contacted by a collection agency over a medical bill within past 12 months. (The rates were 35% for the uninsured and 15% for those with insurance.)

How medical debt becomes credit card debt was the subject of a study by Cindy Zeldin and Mark Rukavina for the Demos Foundation and The Access Project.[80] They surveyed 1150 low and middle income households with credit card debt, documenting that 29% of those households with credit card debt reported that medical expenses contributed to their current level of credit card debt. Among the "medically indebted," the study found:

- 69% had a major medical expense in the previous three years. Within this "medically indebted" group
- 44% had credit card debt higher than $10,000 and 57% had credit card debt higher than $5,000.
- Average credit card debt for the medically-indebted was higher for low- and middle- income households ($11,623) as compared to households without a major medical expense ($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% versus 38%).

In a study conducted at ten community-based organizations in Baltimore City, Maryland in 2002, Thomas P. O'Toole, Jose J. Arbelaez, Robert S. Lawrence surveyed 274 adults.[81] They found:

- 46.2% reported currently owing money for medical care they received
- Average debt load per person was $3,409, almost half of the annual reported income.
- 39.4% reported they had been referred to a collection agency for a medical debt at some point in their lives
- Having medical debt significantly is associated with no medical insurance (60.1% v. 31.5%)

A study by Sydney D. Watson, Margarida Jorge, Andrew Cohen and Robert W. Seifert for The Access Project documented the difficulties families have in dealing with health care expenses. In 2006, they surveyed 383 working families living in the St. Louis, with incomes generally below $35,000. More than half—53%—of respondents currently owed money for medical care.[82] Among those who could not pay their medical debts in full, bad credit and housing problems were widespread.

Paying for Healthcare: A Primary Concern for All Americans

Just last week, Bill Novelli, the CEO of AARP, cited a Gallup Survey of 1,008 adults from April 2-5, 2007, noting that almost half of all Americans are worried about paying medical costs if they become serious ill or have an accident.[83] More than a quarter—28%—describe themselves as "very worried" and another 21% say they are moderately worried. Mr. Novelli urges the millions of AARP members to make health care reform the number one issue in the 2008 elections.

Conclusion

There are more studies, but the point is unmistakable. American families are struggling. For some who have been ill, medical bills are not a problem. They are fully covered by health insurance, they have employers who will pay them even when they are absent from work, or they have the personal resources to weather any financial fallout from their medical problems. But for millions more, our current payment system leaves families juggling bills they cannot pay, taking on debts, borrowing against their homes, and dealing with debt collectors. And for five million families in the past seven years, medical problems are part of their plunge over the financial edge and into bankruptcy.

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[1] The bankruptcy dataset discussed in this testimony was developed with generous funding from the Robert Wood Johnson Foundation, The Ford Foundation, Harvard Law School, and New York University Law School. Provost Teresa Sullivan and Professors Jay Westbrook, David Himmelstein, Robert Lawless, Bruce Markell, Michael Schill, Deborah Thorne, Susan Wachter, Steffie Woolhandler, Katherine Porter, and John Pottow played key roles in developing the bankruptcy dataset.

[2] From 2000 until the first half of 2007, 10.5 million households filed for bankruptcy. Administrative Office of the United States Courts. If about half of these families filed medical bankruptcies, as the data suggest, then about five million families made the trip to the bankruptcy court in the aftermath of a serious medical problem.

[3] Michelle J. White, Why It Pays To File Bankruptcy: A Critical Look at the Incentives Under the U.S. Personal Bankruptcy Law and a Proposal for Change, 65 University of Chicago Law Review 685, 702 (1998) (finding that about 17% of all households would benefit financially from filing bankruptcy—at a time when about 1% of households were filing).

[4] Elizabeth Warren, *Financial Collapse and Class Status: Who Goes Bankrupt?* (Lewtas Lecture), 41 OSGOODE HALL LAW REVIEW 115 (2003) (57.2% had been to college, 56.3% had jobs in the upper 80% of occupational prestige scores, 58.3% were homeowners, and 91.8% had one or more of these indicia of class status).

[5] Robert Lawless and Elizabeth Warren, *The Myth of the Disappearing Business Bankruptcy*, 93 CAL. L. REV. 745 (2005).

[6] This portion of my testimony is drawn largely from Melissa Jacoby and Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 Northwestern Law Review 535 (2006). I am grateful to Professor Jacoby for her permission to draw on this portion of our joint work.

[7] David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. WEB EXCLUSIVE W5-66 exhibit 1 (2005).

[8] David Himmelstein, Deborah Thorne, Elizabeth Warren and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS (February 2, 2005).

[9] Both the Health Affairs article and the Northwestern Law Review article describe the study. The longest and most detailed description of the study is in the Appendix to Elizabeth Warren and Amelia Tyagi, The Two-Income Trap: Why Middle Class Mothers and Fathers Are Going Broke (2003).

[10] *See* Jacoby et al., *Rethinking the Debates*, at 384-385 (explaining over-attribution possibility).

[11] *See* Himmelstein et al, at W5-71.

[12] Of the 1,250 in the core sample, 28 did not answer question twelve. Of the total sample of 1,771 bankruptcy filings (core plus supplemental homeowner), 44 did not answer question twelve.
[13] Debtors were paid the same amount for their participation in the telephone survey ($50) regardless of how many portions they completed. Some may have refused to respond to the medical portion to end the interview more quickly, whether or not their financial had a medical component. At the margins, this might have produced under-representation in the telephone surveys.
[14] *See* figures 1-3.
[15] N = 1,250.
[16] N = 602 (debtors with both telephone survey and written questionnaire).
[17] N = 602. Note that the N drops from the questionnaire data alone (1,250 for the core sample) because the response rate on the follow-up telephone surveys was about half of all the core sample families that completed questionnaires. This means that any data that combine the paper questionnaires and telephone surveys can use only the smaller N from the telephone surveys. Because the "reasons" information is drawn from two sources instead of one, it is both different and more complete than the data reported in Himmelstein, et al.
[18] N = 1,250.
[19] N = 1,250.
[20] N = 1,250.
[21] N = 1,250. The incomes for these households in the year before filing was quite modest. The median income was about $25,000, and even at the 80th percentile, income was only slightly about $40,000. Even an unpaid medical debt of $1,000 would likely cause a strain fo many of these households. Of course, $1,000 is only the threshold number. The telephone surveys completed by a subset of the sample revealed medical debts at much higher amounts. *See* Himmelstein et al., **Error! Bookmark not defined.**at W5-70 (reporting mean out of pocket expenses of $11,854) (N=331).
[22] To estimate the number of families that will be affected, we use the data on bankruptcies from the Administrative Office of the United States ("AO") courts. We follow the AO classification of cases into "business" and "non-business," using the "non-business" classification as a proxy for the number of households filing for bankruptcy. In other work, the AO methods for distinguishing between business and non-business cases have been criticized because the count of "non-business bankruptcies" includes approximately 300,000 self-employed debtors, many of whose small businesses have failed. *See* Robert Lawless and Elizabeth Warren, *The Myth of the Disappearing Business Bankruptcy*, 93 CAL. L. REV. 745 (2005). In addition, the way in which the AO data are reported has changed over time, and this makes it difficult to evaluate trends in business and non-business filing rates from the mid-1980s. For the purposes of this work, however, the difficulties in distinguishing non-business filers from self-employed filers is less important. Whether they are wage earners or entrepreneurs, the non-business bankruptcies represent a household in financial trouble, and this is the appropriate unit of analysis here.
[23] *See, e.g.*, USA Today/Kaiser Family Foundation/Harvard School of Public Health Health Care Costs Survey, Summary and Chartpack, chart 3 (Aug. 2005) (reporting that only small percentage of sample who indicated medical-related financial distress filed bankruptcy); Amanda E. Dawsey & Lawrence M. Ausubel, Informal Bankruptcy (Feb. 2002), *available at* http://www.ausubel.com; Michelle J. White, *Personal Bankruptcy Filing under the 1978 Bankruptcy Act*, 63 IND. L. J. 1, 50 (1987/88) (finding more households would benefit from bankruptcy than actually file); Press Release, Cambridge Consumer Credit Index (Feb. 7, 2005) (based on poll of over 800 adults, reporting "83% of Americans say that debts they have incurred because of medical or dental procedures are burdensome enough to prevent them from buying large ticket items"), *available at* http://www.cambridgeconsumerindex.com/index.asp?content=press_release. *See also* sources cited in note 83.
[24] N=331. *See id.* at W5-69.
[25] *See id.* Among those filers eligible for Medicare and with psychiatric disorders, prescription drugs were the biggest expense for nearly all of them. *See id. Compare* Kenneth M. Langa et al., *Out-of-Pocket Health-Care Expenditures among Older Americans with Cancer*, 7 VALUE IN HEALTH 186, 191 (2004) (nationally representative study of older Americans finding that prescription drugs were the main source of increased out of pocket expenses among people undergoing cancer treatment). Whether or not the elderly will be aided by the Medicare prescription drug bill, *see* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2469 (Dec. 8, 2003), those with trouble

affording medications are not necessarily Medicare-eligible. *See, e.g.*, J. Kennedy & C. Erb, *Prescription noncompliance due to cost among adults with disabilities in the United States*, 92 AM. J. PUB. HEALTH 1120, 1123 (2002) (in the sample, 27% of those with problems paying for drugs were eligible for Medicare).

[26] Himmelstein et al, at W5-69. *See also* Prottas, at 43 (observing that complaints about hospital collection practices may be applicable to other types of medical providers).

[27] These data were collected as part of the telephone survey. Because each family member may have different illnesses or accidents, insurance coverage, and expense profiles, we collected the data for each ill or injured family member in the sample rather than by household. In the telephone survey sample, among the respondents who indicated that they had filed for bankruptcy because of medical problems, there are fifty instances in which a debtor indicated that more than one person had had an illness or injury. Of the fifty, forty-two families reported two ill/injured family members, and eight reported three or more. The questions about the largest expenses were posed to two separate groups. First, it was asked of individuals who had no medical insurance (n=93) or who had insurance but who had experienced a gap in coverage (n=82). We asked whether the identified illness or accident resulted in significant medical debt for these people. For the one hundred and thirteen individuals for whom the respondents said yes to this question, we posed a follow up question to specify which debts caused the greatest financial burden (n=113). We also posed the same line of questions to individuals with continuous insurance coverage (n= 206). For those with continuous coverage who identified significant medical debt (n=83), we asked about the single greatest expense. The combination of the two groups comprises Figure 4. Valid N = 196. The category "other" includes insurance premiums, medical equipment, nursing home care, in-home care, and other unspecified expenses.

[28] U.S. Census Bureau, Statistical Abstract of the United States: 2004-2005, p. 95, tables no. 120-121 (reporting $14.7 billion in out of pocket consumer payments to hospitals, and $212.5 billion overall out of pocket payments in 2002) [hereinafter Statistical Abstract]. Payments to hospitals were less than those to physician and clinical services ($34.2 billion), prescription drugs ($48.6 billion) and nursing home care ($25.9 billion). *Id.*

[29] *Id.* at 109, table no. 154 (reporting 890 million physician office visits as compared to 110.2 million emergency department visits and 83.3 million outpatient department visits in 2002).

[30] *See, e.g.*, Jeffrey J. Ellis et al., *Suboptimal Statin Adherence and Discontinuation in Primary and Secondary Prevention Populations*, 19 J. GEN. INTERNAL MED. 638 (2004); AD Federman , *Don't ask, don't tell - The status of doctor-patient communication about health care costs*, 164 ARCHIVES OF INTERNAL MED. 1723 (2004); Dana P. Goldman et al., *Pharmacy Benefits and the Use of Drugs by the Chronically Ill*, 291 JAMA 2344 (2004); H.A. Huskamp et al., "The *Effect of Incentive-Based Formularies on Prescription Drug Utilization and Spending*, 349 N. E. J. MED 2224 (2003); Kennedy & Erb, *supra* note 25; John D. Piette et al., *Problems Paying Out-of-Pocket Medication Costs Among Older Adults With Diabetes*, 27 DIABETES CARE 384 (2004); John D. Piette et al., *Cost-related medication underuse - Do patients with chronic illnesses tell their doctors?*, 164 ARCHIVES OF INTERNAL MED. 1749 (2004); D. Safran et. al, *Prescription Drug Coverage and Seniors: How Well are States Closing the Gap?* 21 HEALTH AFF. -- WEB EXCLUSIVE W253 (July 31, 2002); M.A. Steinman et al., *Self-Restriction of Medications Due to Cost in Seniors without Prescription Coverage*, 16 J. GEN. INTERN MED. 421 (2001); R. Tamblyn et al., *Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person*, 285 JAMA 421 (2001); Rebecca Voelker, *When Cost is an Adverse Drug Effect, Patients Cut Corners and Risk Health*, 292 JAMA 2201 (2004) (summarizing recent studies).

[31] *See, e.g.*, Langa et al., *supra* note 25, at 190.

[32] N=331 (core plus supplemental homeowner telephone survey sample, unweighted). Valid N = 331. This figure jumps to more than half (51.4%) if the filers with medical problems who charged basic necessities that may relate to health or general well-being are included.

[33] The narrative accounts revealed some rather large amounts being financed through credit. For example, after insurance did not cover an emergency baby delivery, one new parent charged the entire $17,000 bill to a credit card, starting a chain of financial problems. Consumer Bankruptcy Project Phase III Linked Database (on file with authors). A family used credit cards to finance monthly thousands of dollars of medications for a child with non-Hodgkins lymphoma because insurance would pay for blood transfusions but not drugs. A man used credit cards to buy supplies associated with a loved one's cancer treatments. Another filer reported that she regularly charged her health insurance premiums on a credit card. *Id.*

[34] *See* Himmelstein et al., at W5-67, Exhibit 2.
[35] *Id.* at W5-68. In the written questionnaire sample, debtors with a thousand dollars or more in medical bills within the two years prior to filing were more likely than others to use a mortgage to finance medical bills (5.0% vs. 0.8%). *Id.*
[36] *Id.* at W5-68. A "high cost" mortgage refers here to one with an interest rate above 12%, or points plus fees of at least 8%. *Id.*
[37] *See, e.g.*, Sara R. Collins et al., at 18 (one fifth of those with medical bill problems or medical debts charged large debts to credit cards or used home mortgage); Piette et al., *supra* note 30, at 387 (14% of patients in sample, and 23% of those without drug insurance coverage, increased credit card debt to be able to afford prescription drugs); Ha T. Tu, *Rising Health Costs, Medical Debt and Chronic Conditions*, Center for Studying Health System Change Issue Brief No. 88, p. 3 (Sept. 2004) (50% of working age adults with chronic conditions whose families had problems paying medical bills in past year had to borrow money to pay), *available at* http://www.hschange.org/CONTENT/706/; Glenn B. Canner et al., *Recent Developments In Home Equity Lending*, 84 Fed. Res. Bull. 241, 248 tbl.8 (1998) (increase in borrowers indicating medical expenses as use for home equity loans). Other studies have reported the use of consumer credit in categories that have included medical debt. *See, e.g.*, Peter J. Brady et al., *The Effects of Recent Mortgage Refinancing*, Fed. Res. Bull. 441, 446 (July 2000) (39% of 1998 and early 1999 refinancings used for consumer expenditures, which includes medical expenses); HUD-Treasury Task Force on Predatory Lending, Curbing Predatory Home Mortgage Lending 31 (June 2000), available at http://www.treas.gov/press/releases/reports/treasrpt.pdf
(citing a National Home Equity Mortgage Association survey finding that 30% of subprime home equity loans were used for covering medical, educational, and other expenses, as compared to 25% for home improvement and 45% for debt consolidation); Javier Silva, A House of Cards; Refinancing the American Dream, Dēmos Borrowing to Make Ends Meet Briefing Paper #3 (Jan. 2005), *available at* http://www.demos-usa.org/pubs/AHouseofCards.pdf (discussing Federal Reserve System Flow of Funds data from 2001-2002 showing that 25% of home equity fund were used for consumer expenditures, including medical expenses). *See generally* Heather C. McGhee & Tamara Draut, Retiring in the Red; The Growth of Debt Among Older Americans, Dēmos Borrowing to Make Ends Meet Briefing Paper #1, 6 (Jan. 2004) *available at* http://www.demos-usa.org/pubs/Retiring_2ed.pdf (discussing role of medical costs in increased credit card debt among older Americans);
[38] *See* Julie A. Jacob, *Credit to Your Practice: Letting Patients Pay With Plastic*, AM. MED. NEWS., July 29, 2002.
[39] Cindy Zeldin and Mark Rukavina, Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses, Demos and The Access Project (2007).
[40] *See generally* Robert W. Seifert, *The Demand Side of Financial Exploitation: The Case of Medical Debt*, 15 HOUSING POL'Y DEBATE 785,795 (2004). *See also* Johnson v. Rutherford Hosp. and Murfreesboro Bank & Trust Co., 13 B.R. 185 (Bankr. M.D. Tenn. 1981) (hospital arranged for credit).
[41] Citibank Health Card Program, www.citibank.com/us/cards/cardserv/healthcrd/cons_benefits.htm.
[42] *See* www.carecredit.com; Tyler Chin, *In the cards: Getting Paid with Plastic; Innovations in the credit and debit card industry are giving physicians new options for collecting bills*, AM. MED. NEWS, Jan. 12, 2004 (GE Sales Finance declined to discuss in detail but said it was targeting high dollar specialty practices).
[43] *See* www.accessonemedcard.com; Mike Stobbe, *Credit card agency cuts hospitals' losses*, CHARLOTTE OBSERVER, July 11, 2003 (discussing AccessOne program).
[44] *See* Michael Unger, *Just What the Doctor Ordered; Schein's One-Stop Service Ranges from Equipment to Personal Finance*, NEWSDAY, Dec. 30, 1996, at C7.
[45] *See* News Release, *PracticeXpert Launches Pxpert Medical Credit Card Program* (Sept. 4, 2003) (acquiring delinquent accounts from physician, transferring balance to credit card); Chin, *supra* note 42 (PracticeXpert program will be targeting patients with poor credit histories).
[46] *See* News Release, *King Thomason Group Enters into Agreement With Medical Capital Corporation to Market KTG's TotalCare Medical Accounts Receivable Credit Card Program* (April 23,2004). www.kgth.com/main/totalrecovery.htm (citing 95% approval rate for private pay patients). KTG also offers a structured payment plan as an alternative to credit cards.
[47] www.helpcard.com/consumer/helpisprovided.html

[48] This credit product is used by patients of the Inova Health System, to be distinguished from the financier of cosmetic surgery with the same name.
[49] www.healthEZ.com (encouraging employers to offer as supplement to health plans); Larry Werner, *War stories about start-up funding leave 'em laughing*, MINN. STAR TRIB., July 2, 2003, at 1D.
[50] *See* Federal Trade Commission Commentary on Fair and Accurate Credit Transactions Act of 2003, Medical Information Rulemaking (May 27, 2004).
[51] In the 2001 written survey sample, more than a quarter of all filers in the written questionnaire sample identified illness or injury as a reason for filing, whether or not they owed large medical debts. *See* Himmelstein et al., at W5-67 Exhibit 2 (N=1771). *See generally* Jacoby et al., *Rethinking the Debates*, at 388 (54.9% of those who said illness or injury was a reason for filing for bankruptcy did not identify a current debt to a medical provider).
[52] N = 1,250 (core sample). The rate is nearly identical (21.3%) if the homeowner sample is added and weighted into the analysis as well. *See* Himmelstein et al., at W5-67 Exhibit 2.
[53] N=331 (core plus supplemental homeowner telephone survey sample, unweighted).
[54] N=331.
[55] N=331. The filers' narrative accounts, even if not representative, also illustrate the range of circumstances in which income loss follows both longer-term and acute problems. For example, open-heart surgery and its aftermath led to loss of temporary work and a resulting loss of income for one filer. *See* Consumer Bankruptcy Project Phase III Linked Database (on file with author). Others told interviewers they had missed too much work due to chronic illness or hospitalizations and either could not work out an arrangement with employers or were advised by doctors to take different types of jobs. Doctors ordered bed rest for pregnant women who had been in car accidents or who had developed gestational diabetes; one consumed all her allotted family leave before the baby was born, and soon after was fired. A number of others explained that they had difficulty receiving their workers' compensation benefits or were receiving benefits at levels far below their prior incomes. *Id.*
[56] Himmelstein et al., at W5-69. For example, more than a quarter (26.6%) reported cardiovascular problems as a primary or secondary diagnosis. Nearly a third had trauma, orthopedic, or back and spine problems. Almost one out of ten (9.5%) reported cancer. Approximately 10% reported diabetes.
[57] N=391 (core plus supplemental homeowner telephone survey sample, unweighted, measured by people instead of cases). Valid N = 332.
[58] In 15.48% of the cases, the ill or injured person reported having disability insurance. N=391 (core plus supplemental homeowner telephone survey sample, unweighted, measured by people instead of cases). Valid N = 241. Respondents were asked this question only if the ill or injured person at issue was employed part-time or full-time by a third party at the time of the illness or injury. Even if some ultimately could prove entitlement to disability payments under one of the Social Security programs, the level of income replacement would be low and thus would not necessarily forestall major financial trouble. *See generally* TERESA A. SULLIVAN, ELIZABETH WARREN, & JAY LAWRENCE WESTBROOK, THE FRAGILE MIDDLE CLASS; AMERICANS IN DEBT 158-163 (2000).
[59] *See generally* B.F. Hughes et al., *Pediatric femur fractures: Effects of spica cast treatment on family and community*, 15 J. PEDIATRIC ORTHOPEDICS 457 (1995) (discussing costs of casting for femur fractures, including average of three weeks of lost work for parent in families with two working parents); Carol E. Smith et al., *Efficiency of families managing home health care*, 73 ANNALS OF OPERATIONS RES. 157 (1997).
[60] *See* Himmelstein et al., at W5-69.
[61] *See id.*
[62] *See* Consumer Bankruptcy Project Phase III Linked Database (on file with authors).
[63] *See id.*
[64] *See id.*
[65] *See id.*
[66] *See id.*
[67] *See id.*
[68] *See id.*
[69] *See id.*
[70] *See id.*

[71] Ezekial Johnson and James Wright, Are Mormons Bankrupting Utah?, XL Suffolk Law Review 607 (2007).
[72] Utahans and Bankruptcy: Why We're Going Broke, Salt Lake Tribune A-1 (January 11, 2005).
[73] United Way of Salt Lake, Living on the Edge: Utahans Perspectives on Bankruptcy and Financial Stability (2006) (available at www.uw.org/images/PDFs/UWBKReport.pdf).
[74] Trilby de Jung, A Review of Medical Debt in Upstate New York, Empire Justice Center (January 2006).
[75] USA Today, Kaiser Family Foundation, and Harvard School of Public Health, National Survey of Households Affected by Cancer (November 2006).
[76] Deanna L. Sharpe and Dana Lee Baker, Financial Issues Associated with Having a Child with Autism, 28 Journal of Family Economic Issues 247 (March 9, 2007).
[77] Aparna Mathur, Medical Bills and Bankruptcy Filings, American Enterprise Institute Working Paper (July 19, 2006).
[78] The PSID purports to be a cross-section of American families, but the number o families admitting to a bankruptcy filing is about half that of the population in the year asked. This means either that the sample is not representative or that about half of those who filed for bankruptcy denied it. This discrepancy calls into question the use of the database for analyzing bankruptcy issues. See, e.g., *Less Stigma or More Financial Distress: An Empirical Analysis of the Extraordinary Increase in Bankruptcy Filings,* 59 Stanford L. Rev. 213, 245-46 (2006).
[79] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, Seeing Red: Americans Driven into Debt by Medical Bills, The Commonwealth Fund (August 2005).
[80] Cindy Zeldin and Mark Rukavina, Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses, Demos and The Access Project (2007).
[81] Thomas P. O'Toole, Jose J. Arbelaez, Robert S. Lawrence, The Baltimore Community Health Consortium, Medical Debt and Aggressive Debt Restitution Practices, 19 Journal of General Internal Medicine 772-78 (2004).
[82] Sydney D. Watson, Margarida Jorge, Andrew Cohen and Robert W. Seifert, Living in the Red: Medical Debt and Housing Security in Missouri, The Access Project (2007).
[83] Bill Novelli, Where We Stand, AARP Bulletin 31 (July-August 2007).

Chairman CONYERS. Thank you so much.

Mark Rukavina, the executive director of Access, a national resource center. And before that, he was program director for the Summerbridge Community Health Partnership in Massachusetts.

We welcome you to this hearing.

TESTIMONY OF MARK RUKAVINA, EXECUTIVE DIRECTOR, THE ACCESS PROJECT, BOSTON, MA

Mr. RUKAVINA. Thank you, Mr. Chairman.

I would like to thank Chairwoman Sánchez and the Chairman for the invitation to speak at this hearing today on such an important issue, the issue of medical bankruptcy. Far more common than medical bankruptcy, however, is the problem of medical debt. And I am going to focus my comments today on the prevalence and the consequences of medical debt.

Year after year, the Nation's health care spending outpaces the consumer price index. Health care costs now consume 16 percent of our gross domestic product. This spells trouble for the American public. Consumers are expected to pay nearly a quarter of $1 trillion this year in out-of-pocket payments. And this is on top of the health insurance premiums that they pay. For many these costs will convert to medical debt.

Professor Warren mentioned the number of Americans with medical debt. It might come as a surprise to people that nearly two-thirds of these people with medical debt have health insurance. Every fifth insured American carries medical debt.

It seems many Americans are being sold faulty products. In the automobile or airline industry, this level of product failure would not be tolerated by consumers or regulators.

Medical debt has implications. It is a barrier to care. The Access Project has conducted a study of uninsured patients treated at safety net providers. These are providers with a commitment to serve uninsured and under-served populations.

And we have found that nearly half had unpaid medical bills. And of those with medical bills, a quarter of them expressed reluctance to go back to those providers in the future because of the debt that they had.

When it comes to health access, medical debt trumps health insurance. Research from the Kaiser Family Foundation found that medical debt itself is a risk factor in terms of access. Insured people with medical debt have care-seeking patterns similar to the uninsured. They are less likely to fill a prescription, see a specialist. They are more likely to skip treatments or forego ordered tests.

But medical debt also has financial consequences. It depletes savings, destroys credit, and it threatens the American dream of home ownership.

We conducted a study of clients who were seeking services at a consumer credit counseling service. Two in five were there because a medical incident contributed to their debt problem. The commonwealth fund research on medical debt found that for those with medical debt, Americans with medical debt, one quarter could not pay for other basic needs because of this debt.

Nearly two in five used all or most of their savings trying to pay off their medical debt. And another quarter charged their medical

debt on credit cards. People are trying to pay these bills. They simply can't afford to do it.

We conducted another study of people seeking tax preparation assistance at volunteer income tax assistance sites. This was done in early 2005. We found that nearly half of this population had medical debt. And of those with debt, more than a quarter reported housing problems as a result of this debt.

Much of what we have learned about this issue we have learned from people like Donna Smith, people who call us for assistance in resolving the medical debt that they have. And what we see is that these bills pile up. They are bills for ambulance, hospital, physicians, prescriptions, lab services.

On a credit report, all of these bills, each individual bill is a potential strike against them. If unpaid, it can linger for years often long after being written off by the health care provider is bad debt.

In conclusion, I would like to suggest that these problems can be solved if America were to adopt the universal system that provided Americans with affordable, comprehensive access—or access to comprehensive benefits. While this may be years off, there are other steps that can be taken in the short run.

For example, standards for insurance companies could be established that protects people when they get ill. And cost-sharing obligations should be tailored to people's ability to pay. There are other steps that can be taken that address the issue of ruined credit for people who have medical debt.

Too many Americans are healed by our fine medical institutions only to be harmed by the bills that they are unable to pay. Credit reports marred by medical debt can have all sorts of effects far beyond the medical system. It can drive up the cost of homeowners insurance, automobile insurance, limit people's employment opportunities, and block access to affordable credit.

Involuntary medical debt should not be allowed to tarnish people's credit. Medical providers and their agents should be prohibited from reporting this debt to collection agents.

In closing, I would like to thank the Committee for this opportunity to speak and be happy to answer questions when the time is appropriate.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rukavina follows:]

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July 17, 2007

"Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy"

Testimony submitted to the House Committee on the Judiciary
Subcommittee on Commercial and Administrative Law

The problem of Americans filing for personal bankruptcy due to a medical incident, tells only part of the medical debt story. Many more Americans suffer from the financial burden of medical costs and medical debt. Even if they are not forced into bankruptcy, the consequences are serious and sometimes devastating.

Medical Debt

Medical debt is money owed for medical services or products, such as hospital or physician care, ambulance services, prescription drugs or durable medical supplies. It may be owed directly to a provider, a collection agent serving the provider, a credit card company, another lender, a family member or a friend. Medical debt is usually involuntary—that is, it is accrued because of events that cannot be predicted or avoided.

The Financial Burden of Health Care Costs

Between 2000 and 2005 health insurance premiums increased by 73 percent, while workers' wages rose by only 15 percent.[i] Increasing costs have forced many people to drop insurance coverage while other have maintained coverage but with diminished benefits due to higher deductibles, co-insurance, co-payments, limits on benefits, and gaps in coverage.

Researchers have projected that American consumers will spend approximately $250 billions in out-of-pocket costs in 2007.[ii] This is in addition to the premiums paid directly by consumers for their health insurance coverage. For many Americans, these out-of-pocket costs will result in medical debt.

The Prevalence of Medical Debt

The problem of medical debt is widespread. According to a national study done by the Commonwealth Fund, approximately 21% of Americans adults—36 million people—under the age of 65 have medical bills or accrued medical debt that they are paying off over time.[iii]

Other studies estimate that even more are at risk of medical debt. A 2005 study by the Kaiser Family Foundation estimated that 58 million Americans are at risk of incurring medical bills they may not be able to repay; included are Americans uninsured for any part of the year and an estimated 17.6 million people with private insurance coverage that provides them with insufficient protection.[iv]

Nationally, one-quarter of those with medical debt have bills of $4,000 or more and more than three and a half million Americans are carrying more than $10,000 in medical debt.[v] The prevalence of medical debt is even more severe for those with moderate incomes. The Access Project conducted a survey of people seeking assistance through Volunteer Income Tax Assistance sites in early 2005. Most of the respondents had household incomes of less than $36,000. Among this population, nearly half (46%) had medical debt.[vi]

Medical Debt Plagues Americans with Health Insurance

It may come as a surprise to learn that most Americans with medical debt have health insurance. People buy health insurance to protect them from financial ruin should they experience illness or injury. However, nearly two-thirds (62%) of those with medical debt had insurance at the time of their medical incident. The Commonwealth Fund found that nearly one in five (18%) Americans with health insurance medical had bills they could not pay. One-third of these insured Americans who incurred medical debt used all or most of their savings paying health care costs.[vii] The purpose of insurance is to spread risk among a group of people and protect individuals' financial assets in the case of unforeseen incidents. The cases cited above clearly demonstrate that health insurance fails many Americans' in its primary purpose. In the automobile or airline industries, this level of product failure would not be tolerated by consumers or regulators.

Similarly, the Kaiser Family Foundation found that 18 million (16%) of privately insured adults reported significant problems with paying their medical bills.[viii] In an Access Project study linking medical debt and housing problems, we found that slightly

more of the respondents with debt had health insurance at the time they received the care for which they owed money. Though a lack of insurance puts people at great risk for medical debt and the problems resulting from it, those with health insurance are in not way immune from unaffordable medical bills.

Medical Debt is a Barrier to Health Care

The tragedy of medical debt is that it is involuntary incurred for services on which a person's well-being or life may depend. It is debt that cannot be easily planned for and it has far reaching health access and financial implications.

Over and over again, Access Project studies have found that medical debt is linked to delayed care. In our study of uninsured patients with medical debt served by safety-net providers—providers with a mission to serve the uninsured—one-quarter said that medical debt would make them reluctant to seek care at that facility in the future.[ix] Another study examining medical debt among patients at community health centers in Massachusetts found that three in five of those with medical debt delayed getting needed care,[x] slightly more than in Kansas where just under half delayed care.[xi] Reasons for the delay included being embarrassed by outstanding bills, a desire not to take on additional debt or being refused an appointment by a provider because bills were not paid. In the Kansas study, just over one-quarter or respondents changed primary care doctors because of money they owed to their medical provider.

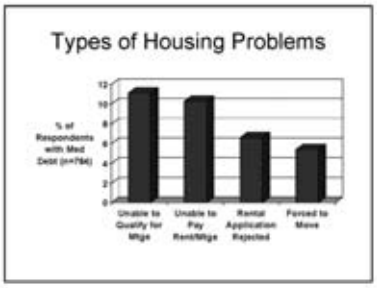
There is a significant body of research documenting that that those without health insurance are more likely to delay care or forego treatment than people with insurance coverage. However, research done by the Kaiser Family Foundation found that the presence of medical debt is also an access risk factor. Insured people with medical debt are nearly four times more likely than those with insurance and no debt to skip a recommended test or treatment (30% vs. 8%) or not get needed care (12% vs. 3%) and more than twice as likely to not fill an order for a prescription drug due to cost (24% vs. 9%). In general, the care seeking patterns among those with private insurance who have medical debt resemble the patterns of people with no insurance coverage. [xii]

Medical Debt Tarnishes Credit

The financial burdens of health care and medical debt deplete savings, destroy credit and threaten the American dream of homeownership.

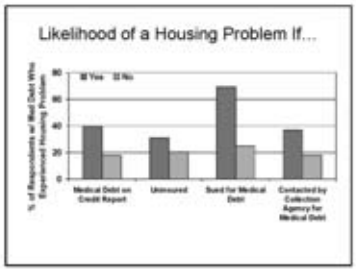
In a study conducted by The Access Project with clients at a consumer credit counseling service, two in five were seeking counseling because a medical incident contributed to the debt problem.[xiii] This surprised even the counselors since medical debt is often masked as credit card debt.

Many medical bills ultimately end up in the hands of the collection industry. One study found that one in five American adults under the age of 65 had been contacted by a collection agency for medical bills.[xiv] Our study of people seeking help through the Volunteer Income Tax Assistance sites found that more than one-quarter said housing problems resulted from medical debt. Problems ranged from being unable to qualify for a mortgage, being turned down from renting a home, and even eviction or foreclosure.



Of the respondents with medical debt, slightly less than half (46%) did not know whether the medical debt was on their credit report. For those who did know, the

respondents with medical debt on their reports were more than twice as likely to report housing problems (39%) than those who said it was not on their reports (18%).



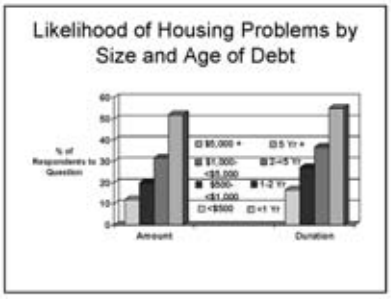
The results were similar for the respondents with medical debt who had been had been contacted by a collection agency. Those contacted by collection agencies were also much more likely to (37%) to report housing problems than those not contacted (18%). Though a small percentage of respondents (5%) had been sued in small claims court, the ramifications loomed large with nearly seven in ten of this group reporting housing problems. Seven percent of those with medical debt filed for personal bankruptcy because of it.[xv]

Earlier this year, The Access Project worked with Demos examining medical debt on credit cards. Demos had commissioned a study of low and middle income households, those with income between 50-120% of local median income, carrying credit card debt for three months or longer. We examined these data and found that 29% of respondents reported that medical expenses contributed to their current level of credit card debt. Of this group, nearly 7 in ten (69%) had a major medical expense in the previous three years. Among the overall sample, 20% reported a major medical expense in the previous three years and that medical expenses contributed to their current credit card debt; we categorized this group as the medically indebted. When we analyzed the data for the medically indebted group, we found that their average credit card debt was

significantly higher ($11,623) than those not medically indebted ($7,964). We also found that the medically indebted were far more likely to be contacted by collection agencies (62%) than those not medically indebted. [xvi]

The Access Project has also learned much about billing and debt problems through direct assistance that we provide to people with medical debt. In helping them resolve their debt problems, we gain insight into the complexity of systems encountered by people with these debts. For example, hospital patients often receive individual invoices for ambulance, hospital, physician, prescription drug, and lab services. All of these bills are potential strikes against them in terms of their credit report.

If medical bills are unpaid, they can linger for years, often long after medical providers have written them off the books as bad debt. Even medical bills with small balances can have significant and detrimental influence over one's credit. Again, our study of housing problems resulting from medical debt is instructive. We found that even respondents with what might be considered small levels of outstanding bills ($500 or less), one in eight reported housing problems with the percentages increasing along with the level of debt



Conclusion

People are at their most vulnerable when they or a loved one experience illness or injury. Being ill and in debt can be a frightening, or even devastating, experience. At present, the American health care system puts far too many American at financial risk. As a result, millions of Americans incur medical debt each year. This debt constricts access to health care and can block access to affordable credit. Repairing the American health care system must be a national priority.

In the long term, American must have universal access to comprehensive benefits. Tens of millions of Americans are uninsured or underinsured. Health insurance does not effectively protect families from financial exposure if they experience illness or injury. The Access Project encourages regulators to carefully consider the wisdom of insurance products that shift the financial burden of health care to Americans through various out-of-pocket expenses but rather establish standards for adequate insurance protection including cost-sharing obligations that are proportionate to household income. Ultimately, Americans must have universal access to comprehensive benefits.

However, in the near term, relief from credit problems related to medical debt could be achieve by limiting medical providers, and their agents, from reporting medical debt to credit agencies. America has some of the world's finest medical institutions staffed by caring and compassionate people committed to healing. However, medical debt can cause harm to these patients. Credit reports marred by medical debt may limit a person's ability to access affordable credit, limit employment and housing opportunities, result in higher costs for homeowners, and increase the costs of other insurance products. The Access Project encourages regulators to consider ways to prevent involuntary medical debt from tarnishing a credit report by prohibiting medical providers and their agents from reporting such debt to credit agencies.

On behalf of The Access Project, thank you for calling attention to this important issue. We hope that you consider this testimony when developing new public policies related to health care, insurance coverage or consumer credit.

[i] *Employer Health Benefits 2005 Annual Survey*, The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 2005.

[ii] C. Borger. "Health Spending Projections Through 2015: Changes On The Horizon" *Health Affairs Web Exclusive*, February 2006.

[iii] S. Collins et al, Gaps in Health Insurance: An All-American Problem: Findings from the Commonwealth Fund Biennial Health Insurance Survey, Commonwealth Fund, April 2006.

[iv] C. Hoffman et al, *Medical Debt and Access to Health Care*, Kaiser Commission on Medicaid and the Uninsured, September 2005.

[v] S. Collins, et al, *Gaps.*

[vi] R. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, November 2005.

[vii] S. Collins, et al, *Gaps*, April 2006.

[viii] C. Hoffman et al, *Medical Debt and Access,* September 2005.

[ix] D. Andrulis et al, *Paying for Health Care When You're Uninsured*: How Much Support Does the Safety Net Offer?, 2003.

[x] C. Pryor et al, Getting Care but Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices, 2004.

[xi] C. Pryor et al, *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security*, 2006.

[xii] C. Hoffman, et al, *Medical Debt and Access,* September 2005.

[xiii] D. Gurewich et al, *Medical Debt and Consumer Credit Counseling Services*, 2004 (Published in Journal of Health Care for the Poor and Underserved).

[xiv] S. Collins, et al *Gaps,* April 2006.

[xv] R. Seifert, *Home Sick,* November 2005.

[xvi] C. Zeldin et al, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses,* (with Demos), 2007.

Attachments to Testimony of Mark Rukavina

July 17, 2007

House Committee on the Judiciary Subcommittee on Commercial and Administrative Law

"Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy"

1. C. Zeldin, M. Rukavina, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses*, (with Demos), 2007.
2. R. Seifert, M. Rukavina, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, Health Affairs Web Exclusive, February 2006.
3. R. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 2005.
4. Access Project Fact Sheet on Medical Debt.

Chairman CONYERS. Thank you for your very interesting testimony.

The only thing not said about Dr. Himmelstein when he was introduced by Subcommittee Chair Sánchez is that he is the cofounder of the Physicians for National Health Plan, some 20 years or more ago, where we now have tens of thousands of doctors who are looking at the same issue that this Subcommittee is looking forward to.

And we commend you for your staying power in this, Dr. Himmelstein, and welcome you.

TESTIMONY OF DAVID U. HIMMELSTEIN, HARVARD MEDICAL SCHOOL, CAMBRIDGE, MA

Mr. HIMMELSTEIN. Thank you, Mr. Chairman. Thank you to Members of the Committee.

I would just say, when we started that organization, a reporter told us that Physicians for National Health Program sounds like furriers for animal rights. But it is now the fastest growing medical organization in the United States.

I am a primary care doctor for 25 years. I have taken care of patients at the public hospital in Cambridge, Massachusetts, and served on the faculty of Harvard Medical School. Caring for patients is tremendously gratifying. But our health financing system constantly thwarts my efforts to help my patients and inflicts financial suffering that I am powerless to alleviate.

I have seen patients die because they have delayed care for diabetes, chest pain, high blood pressure fearing the costs of that care. This needless suffering has motivated me to undertake both the advocacy that you spoke of and the research that I am going to talk about today.

I want to start by saying that health insurance is a little bit like a hospital gown. And for those of you who aren't familiar with our gowns—I know the nurses in the audience will be—I brought along an example. It looks from the front like it covers a lot. But around back, there is a lot left uncovered. And that coverage hangs from a tenuous thread.

Most Americans think they are covered, but few of us are really shielded from the financial ravages of illness. This is the key finding of our bankruptcy study. We went around the country and interviewed nearly 1,800 people in bankruptcy courts. If all we had to do was to look at court records, it would have been a much simpler study. And the problem with those court records, as has been mentioned, is that things like credit card debt hides, in fact, medical debt.

When people take out a second mortgage on their home to pay a medical bill, that doesn't appear in the court records as medical debt. And Mr. Millenson and Mr. Dranove's findings that the Ranking Member, Mr. Cannon, spoke of ignore that fact and, in fact, fail to take in account that ours is the only study that actually asks people directly the question, "What caused your bankruptcy?"

One can only dismiss our finding by saying that people like Ms. Smith when they tell us that medical care or medical bill caused their bankruptcy—one has to say, "No, it didn't," in order to dis-

miss our study. Ours is not just a statistical finding, but one taken from actually talking to people.

I want to emphasize three lessons from our work. First, medical bankruptcy is a middle-class problem. People who file for bankruptcy in the wake of illness are average Americans who did one thing wrong. They got sick.

Most of the three-quarters of a million families bankrupted by illness or medical bills each year are middle-class. Fifty-six percent had gone to college. Fifty-seven percent had owned a home, at least until the financial crisis hit. Eighty percent worked in occupations that social scientists tell us are middle-class or above.

Second, most people bankrupted by illness and medical bills, as has been said here before, had insurance. And that is important for us to know. This is a system that not only fails to work for the uninsured, it fails to work for those with coverage.

In our study, more than three-quarters had coverage at least when they first got sick. Sixty percent had private insurance. But a third of those lost it in the course of their illness.

Often illness caused job loss and with it, loss of coverage. It is like an umbrella that stops functioning once the rain begins.

According to the Wall Street Journal, 27 percent of employers stop health benefits immediately when a worker is too sick to continue working. Twenty-four percent more stop benefits within a year. In many cases, debtors whom we interviewed maintained their insurance but were bankrupted by medical bills because their coverage had gaping holes, co-payments, and deductibles of the kind that Ms. Smith talked about.

The third point I want to emphasize is that the quality of health insurance coverage is deteriorating leaving more and more Americans vulnerable to financial ruin. It has been said that we don't have good trend data. In fact, we have some trend data on this.

Back in 1981, a study asked debtors what caused their bankruptcy. And at that time, 8 percent of the 312,000 bankruptcy filers said that medical problems caused their bankruptcy filing. At the time of our study, somewhere between 46 and 63 percent of the 1.4 million bankruptcy filers in the United States said medical problems or medical bills caused their bankruptcy filing.

In that 20-year period, therefore, we had at least a 23-fold increase in the rate of medical bankruptcy in the United States. We have trend data.

And recent moves by employers to raise co-payments and deductibles under the deceptive rubric of consumer-directed health care are putting many more working families at risk. Under such plans, many families must pay deductibles of $5,000, sometimes even more, before insurance kicks in at all. Personally, I have trouble fathoming calling such coverage consumer-driven, unless perhaps one uses it in the sense that one would say cattle are driven.

Our findings on medical bankruptcy are apparently just the tip of the iceberg, as has been said here before. About 729,000 families are bankrupted by illness and medical bills each year. But many more are under severe financial duress.

Commonwealth fund surveys that have been alluded to tell us that 18 percent of Americans are paying off medical debt over time. Eight percent of insured Americans received a collection call in the

past year. Thirty-nine percent increase in American families paying off medical bills over time, over the past 5 years.

The situation is particularly dire for those with serious illnesses. Among those under 65 who have diabetes, heart disease, high blood pressure or arthritis, more than three out of 10 spend at least 10 percent of their income on health care. Among insured cancer patients, 22 percent say that medical bills consumed virtually all of their savings.

A study of terminally ill patients in ICUs found that the terminal illness caused a moderate or severe financial problem for at least 39 percent of families. And virtually all of those families had coverage.

In sum, our health financing system is failing. Tens of millions are uninsured. Tens of millions more pay for insurance only to find that what they bought in good faith was a defective product. Health insurance is not working.

At doctors' offices and hospitals around our Nation the first question patients face is how will you be paying for this. In Canada where medical bankruptcy is rare and in Sweden and in France and in the rest of the developed world, the first question is how can I help you. These differing questions reflect not only the inhumanity of our care, but also its inefficiency.

We waste hundreds of billions annually on the paperwork required by our complex and redundant private insurance system. Diverting these dollars from bureaucracy to care would allow us to extend coverage to all Americans and to eliminate co-payments and deductibles without increasing health spending. Indeed, our government already spends more per capita on health care than any Nation with national health insurance.

National health insurance such as that that you, Mr. Chairman, have proposed would wipe out medical debt. And nothing short of that will work.

I thank you for your attention.

[The prepared statement of Mr. Himmelstein follows:]

PREPARED STATEMENT OF DAVID U. HIMMELSTEIN

Bankrupting America: The Failure of the U.S. Health Insurance System

David U. Himmelstein, M.D.

Associate Professor of Medicine, Harvard Medical School
Co-Founder, Physicians for a National Health Program

Testimony Presented to the House Judiciary Committee, Subcommittee on Commercial and Administrative Law
July 17, 2007

Summary/Oral Testimony

My name is David Himmelstein. For the past 25 years I have served as a primary care physician at Cambridge Hospital, the public hospital in Cambridge Massachusetts. I also serve on the faculty of Harvard Medical School. Caring for patients is tremendously gratifying, but our health financing system constantly thwarts my efforts to help patients, and inflicts enormous financial suffering that I am powerless to alleviate. I have seen patients die because they delayed care – for diabetes, chest pain, high blood pressure - fearing the costs. This needless suffering has motivated me to undertake research to systematically document the failings of our health care system, and has also led me to advocate for health care reform.

Health insurance is a bit like a hospital gown. From the front it appears to shield the essentials. Closer inspection, however, reveals a lot uncovered behind – and only a tenuous thread prevents full exposure.

Most Americans think they're covered. But few of us are really shielded from the financial ravages of illness. This is the key finding from the 2001 Harvard Consumer Bankruptcy Study[1] - the most comprehensive examination of medical bankruptcy ever performed. I served as a Principal Investigator for that study, and attach a copy of a scholarly article reporting its principal medical findings. Professor Warren – another of

the Principal Investigators – is here today and will describe in detail many of these findings.

I want to emphasize three lessons from our work

First, medical bankruptcy is a middle class problem. Most of the three-quarters of a million families bankrupted by illness or medical bills each year were solidly middle class. 56% had gone to college and 57% owned a home (at least until financial crisis hit). 80% worked in occupations that social scientists would classify as "middle class."

Second, most people bankrupted by illness and medical bills have insurance. In our study of medical debtors, more than three quarters had coverage - at least when they first got sick. 60% had private insurance, but one third of them lost it during the course of their illness. Often, illness caused job loss, and with it the loss of coverage. According to the Wall Street Journal, 27% of employers stop health benefits immediately when a worker is too sick to work, and another 24% stop benefits within a year[2]. In many cases, maintained their insurance, but were bankrupted by medical bills because their coverage had gaping holes – co-payments, deductibles, and exclusions.

Third, the quality of health insurance coverage is deteriorating, leaving more and more Americans vulnerable to financial ruin. Between 1981 and 2001 medical bankruptcies increased more than 20 fold[3], driven by rising medical costs and declining coverage. And recent moves by employers to sharply raise co-payments and deductibles

– under the deceptive rubric "consumer driven healthcare" - are putting many moe working families at risk. Under such plans, many families must pay deductibles of $5000 before insurance kicks in. Personally, I cannot fathom calling such coverage "consumer driven", except, perhaps, in the sense that cattle are driven.

Our findings on medical bankruptcy are apparently just the tip of the iceberg. About 729,000 families are bankrupted by illness and medical bills each year, but many more are under severe financial duress. Surveys by the Commonwealth Fund indicate that 18% of INSURED non-elderly Americans are paying off medical debts over time, and 8% had received a call from a collection agency regarding a medical debt in the past year[4]. According to a Kaiser Foundation survey, one quarter of American families had a problem paying a medical bill in 2006, a 39% increase in the past decade[5].

The situation is particularly dire for those with serious illnesses. Among people under 65 who have diabetes, heart disease, high blood pressure or arthritis, more than 3 out of ten spend at least 10% of their income on healthcare[6]. Among INSURED cancer patients, 22% report that medical bills consumed all or most of their savings; 3% declared bankruptcy; and 7% were left without enough money for food, heat or housing[7]. A study of terminally ill patients in ICUs found that the terminal illness caused a moderate or severe financial problem for 39% of families – and virtually all of these patients had insurance[8].

In sum, our health financing system is failing. Tens of millions are uninsured, tens of millions more pay for private health insurance only to find out once they're ill that they have bought a defective product. Only national health insurance that provides first dollar, comprehensive, non-cancellable coverage can offer real protection to American families.

At doctors' offices and hospitals around our nation, the first question patients face is "How will you be paying for this?" In Canada (where medical bankruptcy is rare[9]) and Sweden and France and the rest of the developed world the first question is "How can I help you?" These differing questions reflect not only the inhumanity of our care, but also its inefficiency. We waste hundreds of billions of dollars annually on the paperwork required by our complex and redundant private insurance system[10]. Diverting these dollars from bureaucracy to care would allow us to extend coverage to all Americans, and eliminate co-payment and deductibles, without any increase in health spending. Indeed, our government already spends more per capita on healthcare than any of nation with national health insurance.

National health insurance, such as that proposed by Chairman Conyers, would wipe out medical debt. Nothing short of that will work.

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MARKETWATCH

Illness And Injury As Contributors To Bankruptcy

Even universal coverage could leave many Americans vulnerable to bankruptcy unless such coverage was more comprehensive than many current policies.

by David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler

ABSTRACT: In 2001, 1.458 million American families filed for bankruptcy. To investigate medical contributors to bankruptcy, we surveyed 1,771 personal bankruptcy filers in five federal courts and subsequently completed in-depth interviews with 931 of them. About half cited medical causes, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced medical bankruptcy. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage. Even middle-class insured families often fall prey to financial catastrophe when sick.

> If the debtor be insolvent to serve creditors, let his body be cut in pieces on the third market day. It may be cut into more or fewer pieces with impunity. Or, if his creditors consent to it, let him be sold to foreigners beyond the Tiber.
> —Twelve Tables, Table III, 6 (ca. 450 B.C.)

OUR BANKRUPTCY SYSTEM works differently from that of ancient Rome; creditors carve up the debtor's assets, not the debtor. Even so, bankruptcy leaves painful problems in its wake. It remains on credit reports for a decade, making everything from car insurance to house payments more expensive.[1] Debtors' names are often published in the newspaper, and the fact of their bankruptcy may show up whenever someone tries to find them via the Internet. Potential employers who run routine credit checks (a common screening practice) will discover the bankruptcy, which can lead to embarrassment or, worse, the lost chance for a much-needed job.[2]

Personal bankruptcy is common. Nearly 1.5 million couples or individuals filed bankruptcy petitions in 2001, a 360 percent increase since 1980.[3] Fragmentary data from the

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legal literature suggest that illness and medical bills contribute to bankruptcy. Most previous studies of medical bankruptcy, however, have relied on court records—where medical debts may be subsumed under credit card or mortgage debt—or on responses to a single survey question.[4] None has collected detailed information on medical expenses, diagnoses, access to care, work loss, or insurance coverage. Research has been impeded both by the absence of a national repository for bankruptcy filings and by debtors' reticence to discuss their bankruptcy; in population-based surveys, only half of those who have undergone bankruptcy admit to it.[5]

The health policy literature is virtually silent on bankruptcy, although a few studies have looked at impoverishment attributable to illness. In his 1972 book, Sen. Edward Kennedy (D-MA) gave an impressionistic account of "sickness and bankruptcy."[6] The likelihood of incurring high out-of-pocket costs was incorporated into older estimates of the number of underinsured Americans: twenty-nine million in 1987.[7] About 16 percent of families now spend more than one-twentieth of their income on health care.[8] Among terminally ill patients (most of them insured), 39 percent reported that health care costs caused moderate or severe financial problems.[9] Medical debt is common among the poor, even those with insurance, and interferes with access to care.[10] At least 8 percent, and perhaps as many as 21 percent, of American families are contacted by collection agencies about medical bills annually.[11]

Our study provides the first extensive data on the medical concomitants of bankruptcy, based on a survey of debtors in bankruptcy courts. We address the following questions: (1) Who files for bankruptcy? (2) How frequently do illness and medical bills contribute to bankruptcy? (3) When medical bills contribute, how large are they and for what services? (4) Does inadequate health insurance play a role in bankruptcy? (5) Does bankruptcy compromise access to care?

A Brief Primer On Bankruptcy

"Bankrupt" is not synonymous with "broke." "Bankrupt" means filing a petition in a federal court asking for protection from creditors via the bankruptcy laws. A single petition may cover an individual or married couple. The instant a debtor files for bankruptcy, the court assumes legal control of the debtor's assets and halts all collection efforts.

Shortly after the filing, a court-appointed trustee convenes a meeting to inventory the debtor's assets and debts and to determine which assets are exempt from seizure. States may regulate these exemptions, which often include work tools, clothes, Bibles, and some equity in a home.

About 70 percent of all consumer debtors file under Chapter 7 of the Bankruptcy Code; most others file under Chapter 13. In Chapter 7 the trustee liquidates all nonexempt assets—although 96 percent of debtors have so little unencumbered property that there is nothing left to liquidate. At the conclusion of the bankruptcy, the debtor is freed from many debts. In Chapter 13 the debtor proposes a repayment plan, which extends for up to five years. Chapter 13 debtors may retain their property so long as they stay current with their repayments.

Under both chapters, taxes, student loans, alimony, and child support remain payable in full, and debtors must make payments on all secured loans (such as home mortgages and car loans) or forfeit the collateral.

Study Data And Methods

This study is based on a cohort of 1,771 bankruptcy filings in 2001. For each filing, a debtor completed a written questionnaire at the mandatory meeting with the trustee, and we abstracted financial data from public court records. In addition, we conducted follow-up telephone interviews with about half (931) of these debtors.

■ **Sampling strategy.** We used cluster sampling to assemble a cohort of households filing for personal bankruptcy in five (of the seventy-seven total) federal judicial districts.[12] We collected 250 questionnaires in each district, representative of the proportion of Chap-

ters 7 and 13 filings in that district. These 1,250 cases constitute our "core sample." For planned studies on housing, we collected identical data from an additional 521 homeowners filing for bankruptcy. We based our analyses on all 1,771 bankruptcies with responses weighted to maintain the representativeness of the sample.[13]

Data collection. With the cooperation of the judges in each district, we contacted the trustees who officiate at meetings with debtors. The trustees agreed to distribute, or to allow a research assistant to distribute, a self-administered questionnaire to debtors appearing at the bankruptcy meeting. Questionnaires (which were available in English and Spanish) included a cover letter explaining the research project and human subjects protections and encouraging debtors to consult their attorneys (who were almost always present) before participating.

The questionnaire asked about demographics, employment, housing, and specific reasons for filing for bankruptcy; it also asked whether the debtor had medical debts exceeding $1,000, had lost two or more weeks of work-related income because of illness, or had health insurance coverage for themselves and all dependents at the time of filing, and whether there had been a gap of one month or more in that coverage during the past two years. In joint filings, we collected demographic information for each spouse.

During the spring and summer of 2001 we collected questionnaires from consecutive debtors in each district until the target number was reached.[14]

Follow-up telephone interviews. The written questionnaire distributed at the time of bankruptcy filing invited debtors to participate in future telephone interviews, for which they would receive $50; 70 percent agreed to such interviews. We ultimately completed follow-up telephone interviews with 931 of the 1,771 debtor families, a response rate of 53 percent.[15] The telephone interviews, conducted between June 2001 and February 2002 using a structured, computer-assisted protocol, explored financial, housing, and medical issues. Many debtors also provided a narrative description of their bankruptcy experience.

Detailed medical questions. Each of the 931 interviewees was asked if any of the following had been a significant cause of their bankruptcy: an illness or injury; the death of a family member; or the addition of a family member through birth, adoption, custody, or fostering. Those who answered yes to this screening question were queried about diagnoses, health insurance during the illness, and medical care use and spending. Interviewers collected information about each household member with medical problems. In total, we collected in-depth medical information on 391 people with health problems in 332 debtor households.

Data analysis. We used data from the self-administered questionnaires (and court records) obtained from all 1,771 filers to analyze demographics, health coverage at the time of filing, and gaps in coverage in the two years before filing.

We also used the questionnaire to estimate how frequently illness and medical bills contributed to bankruptcy. We developed two summary measures of medical bankruptcy. Under the rubric "Major Medical Bankruptcy" we included debtors who either (1) cited illness or injury as a specific reason for bankruptcy, or (2) reported uncovered medical bills exceeding $1,000 in the past years, or (3) lost at least two weeks of work-related income because of illness/injury, or (4) mortgaged a home to pay medical bills. Our more inclusive category, "Any Medical Bankruptcy," included debtors who cited any of the above, or addiction, or uncontrolled gambling, or birth, or the death of a family member.[16]

Data from the 931 follow-up telephone interviews were used to analyze hardships experienced by debtors in the period surrounding their bankruptcy, including problems gaining access to medical care. The in-depth medical interviews regarding 391 people with medical problems are the basis for our analyses of which household members were ill, diagnoses, health insurance at onset of illness, and out-of-pocket spending. Two physicians

(Himmelstein and Woolhandler) coded the diagnoses given by debtors into categories for analysis.

SAS and SUDAAN were used for statistical analyses, adjusting for complex sample design. To extrapolate our findings nationally, we assumed that our core sample was representative of the 1,457,572 households filing for bankruptcy during 2001. Human subject committees at Harvard Law School and the Cambridge Hospital approved the project.

Study Findings

Who files for bankruptcy? Exhibit 1 displays the demographic characteristics of our weighted sample of 1,771 bankruptcy filers. The average debtor was a forty-one-year-old woman with children and at least some college education. Most debtors owned homes; their occupational prestige scores place them predominantly in the middle or working classes.

On average, each bankruptcy involved 1.32 debtors (reflecting some joint filings by married couples) and 1.33 dependents. Extrapolating from our data, the 1.5 million personal bankruptcy filings nationally in 2001 involved 3.9 million people: 1.9 million debtors, 1.3 million children under age eighteen, and 0.7 million other dependents.

Medical causes of bankruptcy. Exhibit 2 shows the proportion of debtors (N = 1,771) citing various medical contributors to their bankruptcy and the estimated number of debtors and dependents nationally affected by each cause. More than one-quarter cited illness or injury as a specific reason for bankruptcy; a similar number reported uncovered medical bills exceeding $1,000. Some debtors cited more than one medical contributor. Nearly half (46.2 percent) (95 percent confidence interval = 43.5, 48.9) of debtors met at least one of our criteria for "major medical bankruptcy." Slightly more than half (54.5 percent) (95 percent CI = 51.8, 57.2) met criteria for "any medical bankruptcy."

A lapse in health insurance coverage during the two years before filing was a strong predictor of a medical cause of bankruptcy (Exhibit 3). Nearly four-tenths (38.4 percent) of debtors who had a "major medical bankruptcy" had experienced a lapse, compared with 27.1 percent of debtors with no medical cause ($p < .0001$). Surprisingly, medical debtors were no less likely than other debtors to have coverage at the time of filing. (More detailed coverage and cost data for the subsample we interviewed appears below.)

Medical debtors resembled other debtors in

EXHIBIT 1
Demographic Characteristics Of Primary Debtors In Bankruptcy Filings, 2001

	All bankruptcies	Major medical bankruptcies[a]
Median age (years)	41	42
Percent male[b]	45.1%	44.2%
Percent of households filing under Chapter 7	62.2%	62.3%
Average number of debtors and dependents per bankruptcy	2.65	2.75
Percent with at least some college education	53.5%	55.8%
Percent current homeowners or lost home in past 5 years	55.3%	56.5%
Percent with occupational prestige scores above 20	81.2%	80.0%
Median income in year prior to bankruptcy filing	$25,000	$24,500

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

NOTE: $P > .05$ for all comparisons between debtors with a major medical cause and other debtors.

[a] Bankruptcies meeting at least one of the following criteria: illness or injury listed as specific reason, uncovered medical bills exceeding $1,000, lost at least two weeks of work-related income because of illness/injury, or mortgaged home to pay medical bills.

[b] Data are for primary and secondary debtors combined.

EXHIBIT 2
Medical Causes Of Bankruptcy, 2001

	Percent of bankruptcies	Number of debtors and dependents in affected U.S. families annually[a]
Specific reason for bankruptcy cited by debtor		
Illness or injury	28.3	1,039,880
Birth/addition of new family member	7.7	421,256
Death in family	7.6	281,309
Alcohol or drug addiction	2.5	109,180
Uncontrolled gambling	1.2	39,566
Debtor or spouse lost at least 2 weeks of work-related income because of illness/injury	21.3	825,113
Uncovered medical bills exceeding $1,000 in 2 years before filing	27.0	1,150,302
Mortgaged home to pay medical bills	2.0[b]	64,000
Major medical cause (illness or injury listed as specific reason, or uncovered medical bills exceeding $1,000, or lost at least 2 weeks of work-related income because of illness/injury, or mortgaged home to pay medical bills)	46.2	1,850,098
Any medical cause (any of the above)	54.5	2,227,000

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.
[a] Extrapolation based on number of bankruptcy filings during 2001 and household size of debtors citing each cause.
[b] Percentage based on homeowners rather than all debtors.

EXHIBIT 3
Health Insurance Status Of Debtors With And Without Medical Causes Of Bankruptcy, 2001

	Percent of debtors citing any medical cause of bankruptcy[a]	Percent of debtors citing major medical cause of bankruptcy[b]	Percent of debtors citing no medical cause of bankruptcy
Debtor or a dependent uninsured at time of bankruptcy filing	32.0[c]	32.6[c]	34.5
Debtor or a dependent had a lapse in coverage during past 2 years	37.7****	38.4****	27.1

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.
[a] Bankruptcy meeting one or more of the following criteria: illness, injury, addition to family, death, alcoholism, drug addiction, or uncontrolled gambling as reason for bankruptcy; or debtor/spouse lost at least 2 weeks of work-related income because of illness/injury; or uncovered medical bills exceeding $1,000; or mortgaged home to pay medical bills.
[b] Bankruptcy meeting one or more of the following criteria: illness or injury as specific reason for bankruptcy; or uncovered medical bills exceeding $1,000; or debtor/spouse lost at least 2 weeks of work-related income because of illness/injury; or mortgaged home to pay medical bills.
[c] p not significant for comparison to debtors citing no medical cause of bankruptcy.
****$p < .001$ for comparison to debtors citing no medical cause of bankruptcy.

most other respects (Exhibit 1). However, the "major medical bankruptcy" group was 16 percent ($p < .03$) less likely than other debtors to cite trouble managing money as a cause of their bankruptcy (data not shown).

■ Privations in the period surrounding bankruptcy. In our follow-up telephone interviews with 931 debtors, they reported substantial privations. During the two years before filing, 40.3 percent had lost telephone service; 19.4 percent had gone without food; 53.6 percent had gone without needed doctor or dentist visits because of the cost; and 43.0 percent had failed to fill a prescription, also because of the cost. Medical debtors experienced more problems in access to care than other debtors did; three-fifths went without a needed doctor or dentist visit, and nearly half failed to fill a prescription (Exhibit 4).

Medical debt was also associated with mortgage problems. Among the total sample of 1,771 debtors, those with more than $1,000 in medical bills were more likely than others to have taken out a mortgage to pay medical bills (5.0 percent versus 0.8 percent). Fifteen percent of all homeowners who had taken out a second or third mortgage cited medical expenses as a reason. Follow-up phone interviews revealed that among homeowners with high-cost mortgages (interest rates greater than 12 percent, or points plus fees of at least 8 percent), 13.8 percent cited a medical reason for taking out the loan.

Following their bankruptcy filings, about one-third of debtors continued to have problems paying their bills. Medical debtors reported particular problems making mortgage/rent payments and paying for utilities (Exhibit

EXHIBIT 4
Privations Experienced By Households In The Period Surrounding Bankruptcy, 2001

Privation in households reporting problems due to finances in the 24 months before filing for bankruptcy	Any medical cause of bankruptcy[a]	Major medical cause of bankruptcy[b]	No medical cause of bankruptcy
Went without food	21.1%[c]	21.8%[c]	17.0%
Water or electricity shut off	30.2[c]	29.8[c]	26.4
Lost phone service	43.4[c]	43.6[c]	35.9
Moved because of financial difficulties	17.0[c]	17.8[c]	14.3
Lost insurance (home, car, life, or health)	47.4****	46.7***	34.6
Went without a needed doctor/dentist visit	59.5****	60.7****	45.0
Failed to fill a prescription	46.7**	49.6***	37.6
Changed care arrangements for an elderly relative	6.7**	6.7**	2.7
Privation in households reporting continuing financial problems 3–12 months after filing for bankruptcy			
Any problem paying bills	32.7[c]	31.1[c]	27.5
Problem paying mortgage/rent	13.8**	12.9[c]	9.1
Problem paying utilities	15.7**	14.9[c]	9.6

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

[a] Bankruptcy meeting one or more of the following criteria: illness, injury, addition to family, death, alcoholism, drug addiction, or uncontrolled gambling as reason for bankruptcy; or debtor/spouse lost at least two weeks of work-related income because of illness/injury; or uncovered medical bills exceeding $1,000; or mortgaged home to pay medical bills. *P* values are for comparisons to bankrupt households citing no medical cause of bankruptcy.

[b] Bankruptcy meeting one or more of the following criteria: illness or injury as specific reason for bankruptcy; or uncovered medical bills exceeding $1,000; or debtor/spouse lost at least two weeks of work-related income because of illness/injury; or mortgaged home to pay medical bills. *P* values are for comparisons to bankrupt households citing no major medical cause of bankruptcy.

[c] Not significant ($p > .05$).

*$p < .10$ **$p < .05$ ***$p < .01$ ****$p < .001$

4). Although our interviews occurred soon after the bankruptcy filings (seven months, on average), many debtors had already been turned down for jobs (3.1 percent), mortgages (5.8 percent), apartment rentals (4.9 percent), or car loans (9.3 percent) because of the bankruptcy on their credit reports.

Medical diagnoses, spending, and type of coverage. Our interviews yielded detailed data on diagnoses, health insurance coverage, and medical bills for 391 debtors or family members whose medical problems contributed to bankruptcy. In three-quarters of cases, the person experiencing the illness/injury was the debtor or spouse of the debtor; in 13.3 percent, a child; and in 8.2 percent, an elderly relative.

Illness begot financial problems both directly (because of medical costs) and through lost income. Three-fifths (59.9 percent) of families bankrupted by medical problems indicated that medical bills (from medical care providers) contributed to bankruptcy; 47.6 percent cited drug costs; 35.3 percent had curtailed employment because of illness, often (52.8 percent) to care for someone else. Many families had problems with both medical bills and income loss.

Families bankrupted by medical problems cited varied, and sometimes multiple, diagnoses. Cardiovascular disorders were reported by 26.6 percent; trauma/orthopedic/back problems by nearly one-third; and cancer, diabetes, pulmonary, or mental disorders and childbirth-related and congenital disorders by about 10 percent each. Half (51.7 percent) of the medical problems involved ongoing chronic illnesses.

Our in-depth interviews with medical debtors confirmed that gaps in coverage were a common problem. Three-fourths (75.7 percent) of these debtors were insured at the onset of the bankrupting illness. Three-fifths (60.1 percent) initially had private coverage, but one-third of them lost coverage during the course of their illness. Of debtors, 5.7 percent had Medicare, 8.4 percent Medicaid, and 1.6 percent veterans/military coverage. Those covered under government programs were less likely than others to have experienced coverage interruptions.

Few medical debtors had elected to go without coverage. Only 2.9 percent of those who were uninsured or suffered a gap in coverage said that they had not thought they needed insurance; 55.9 percent said that premiums were unaffordable; 7.1 percent were unable to obtain coverage because of preexisting medical conditions; and most others cited employment issues, such as job loss or ineligibility for employer-sponsored coverage.

Debtors' out-of-pocket medical costs were often below levels that are commonly labeled catastrophic. In the year prior to bankruptcy, out-of-pocket costs (excluding insurance premiums) averaged $3,686 (95 percent CI = $2,693, $4,679) (Exhibit 5). Presumably, such costs were often ruinous because of concomitant income loss or because the need for costly care persisted over several years. Out-of-pocket costs since the onset of illness/injury averaged $11,854 (95 percent CI = $8,532, $15,175). Those with continuous insurance coverage paid $734 annually in premiums on average, over and above the expenditures detailed above. Debtors with private insurance at the onset of their illnesses had even higher out-of-pocket costs than those with no insurance (Exhibit 5). This paradox is explained by the very high costs—$18,005—incurred by patients who initially had private insurance but lost it. Among families with medical expenses, hospital bills were the biggest medical expense for 42.5 percent, prescription medications for 21.0 percent, and doctors' bills for 20.0 percent. Virtually all of those with Medicare coverage, and most patients with psychiatric disorders, said that prescription drugs were their biggest expense.

The human face of bankruptcy. Debtors' narratives painted a picture of families arriving at the bankruptcy courthouse emotionally and financially exhausted, hoping to stop the collection calls, save their homes, and stabilize their economic circumstances. Many of the debtors detailed ongoing problems with access to care. Some expressed fear that their medical care providers would refuse

EXHIBIT 5
Out-Of-Pocket Medical Spending Since Illness Onset Of Debtors Citing Medical Reasons For Bankruptcy, By Insurance Coverage And Diagnosis, 2001

Group	Mean out-of-pocket expenditure ($)
All debtors citing medical reasons	11,854
Insurance at onset of illness	
Private	13,460
Medicare	8,118
Medicaid	8,195
Uninsured	10,893
Covered at onset of illness but gap since then	
Yes	14,339
No	9,898
Highest-cost diagnoses	
Cancer	35,878
Neurologic diseases	15,560
Mental disorders	15,478
Death (any cause)	17,283

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

to continue their care, and a few recounted actual experiences of this kind. Several had used credit cards to charge medical bills they had no hope of paying.

The co-occurrence of medical and job problems was a common theme. For instance, one debtor underwent lung surgery and suffered a heart attack. Both hospitalizations were covered by his employer-based insurance, but he was unable to return to his physically demanding job. He found new employment but was denied coverage because of his preexisting conditions, which required costly ongoing care. Similarly, a teacher who suffered a heart attack was unable to return to work for many months, and hence her coverage lapsed. A hospital wrote off her $20,000 debt, but she was nonetheless bankrupted by doctors' bills and the cost of medications.

A second common theme was sounded by parents of premature infants or chronically ill children; many took time off from work or incurred large bills for home care while they were at their jobs.

Finally, many of the insured debtors blamed high copayments and deductibles for their financial ruin. For example, a man insured through his employer (a large national firm) suffered a broken leg and torn knee ligaments. He incurred $13,000 in out-of-pocket costs for copayments, deductibles, and uncovered services—much of it for physical therapy.

Discussion

Bankruptcy is common in the United States, involving nearly four million debtors and dependents in 2001; medical problems contribute to about half of all bankruptcies. Medical debtors, like other bankruptcy filers, were primarily middle class (by education and occupation). The chronically poor are less likely to build up debt, have fewer assets (such as a home) to protect, and have less access to the legal resources needed to navigate a complex financial rehabilitation. The medical debtors we surveyed were demographically typical Americans who got sick. They differed from others filing for bankruptcy in one important respect: They were more likely to have experienced a lapse in health coverage. Many had coverage at the onset of their illness but lost it. In other cases, even continuous coverage left families with ruinous medical bills.

Study strengths and limitations. Our study's strengths are the use of multiple overlapping data sources; a large sample size; geo-

graphic diversity; and in-depth data collection. Although our sample may not be fully representative of all personal bankruptcies, the Chapter 7 filers we studied resemble Chapter 7 filers nationally (the only group for whom demographic data has been compiled nationally from court records).[17] Several indicators suggest that response bias did not greatly distort our findings.[18]

As in all surveys, we relied on respondents' truthfulness. Might some debtors blame their predicament on socially acceptable medical problems rather than admitting to irresponsible spending? Several factors suggest that our respondents were candid. First, just prior to answering our questionnaire, debtors had filed extensive financial information with the court under penalty of perjury—information that was available to us in the court records and that virtually never contradicted the questionnaire data. They were about to be sworn in by a trustee (who often administered our questionnaire) and examined under oath. At few other points in life are full disclosure and honesty so aggressively emphasized.

"The privations suffered by many debtors belie the common perception that bankruptcy is an 'easy way out.' "

Second, the details called for in our telephone interview—questions about out-of-pocket medical expenses, who was ill, diagnoses, and so forth—would make a generic claim that "we had medical problems" difficult to sustain. Third, one of us (Thorne) interviewed (for other studies) many debtors in their homes. Almost all specifically denied spendthrift habits, and observation of their homes supported these claims. Most reflected the lifestyle of people under economic constraint, with modest furnishings and few luxuries. Finally, our findings receive indirect corroboration from recent surveys of the general public that have found high levels of medical debt, which often result in calls from collection agencies.[19]

Even when data are reliable, making causal inferences from a cross-sectional study such as ours is perilous. Many debtors described a complex web of problems involving illness, work, and family. Dissecting medical from other causes of bankruptcy is difficult. We cannot presume that eliminating the medical antecedents of bankruptcy would have prevented all of the filings we classified as "medical bankruptcies." Conversely, many people financially ruined by illness are undoubtedly too ill, too destitute, or too demoralized to pursue formal bankruptcy. In sum, bankruptcy is an imperfect proxy for financial ruin.

Trends in medical bankruptcy. Although methodological inconsistencies between studies preclude precise quantification of time trends, medical bankruptcies are clearly increasing. In 1981 the best evidence available suggests that about 25,000 families filed for bankruptcy in the aftermath of a serious medical problem (8 percent of the 312,000 bankruptcy filings that year).[20] Our findings suggest that the number of medical bankruptcies had increased twenty-threefold by 2001. Since the number of bankruptcy filings rose 11 percent in the eighteen months after the completion of our data collection, the absolute number of medical bankruptcies almost surely continues to increase.[21]

Policy implications. Our data highlight four deficiencies in the financial safety net for American families confronting illness. First, even brief lapses in insurance coverage may be ruinous and should not be viewed as benign. While forty-five million Americans are uninsured at any point in time, many more experience spells without coverage. We found little evidence that such gaps were voluntary. Only a handful of medical debtors with a gap in coverage had chosen to forgo insurance because they had not perceived a need for it; the overwhelming majority had found coverage unaffordable or effectively unavailable. The privations suffered by many debtors—going without food, telephone service, electricity, and health care—lend credence to claims that coverage was unaffordable and belie the com-

mon perception that bankruptcy is an "easy way out."

Second, many health insurance policies prove to be too skimpy in the face of serious illness. We doubt that such underinsurance reflects families' preference for risk; few Americans have more than one or two health insurance options. Many insured families are bankrupted by medical expenses well below the "catastrophic" thresholds of high-deductible plans that are increasingly popular with employers. Indeed, even the most comprehensive plan available to us through Harvard University leaves faculty at risk for out-of-pocket expenses as large as those reported by our medical debtors.

Third, even good employment-based coverage sometimes fails to protect families, because illness may lead to job loss and the consequent loss of coverage. Lost jobs, of course, also leave families without health coverage when they are at their financially most vulnerable.

Finally, illness often leads to financial catastrophe through loss of income, as well as high medical bills. Hence, disability insurance and paid sick leave are also critical to financial survival of a serious illness.

ONLY BROAD REFORMS can address these problems. Even universal coverage could leave many Americans vulnerable to bankruptcy unless such coverage was much more comprehensive than many current policies. As in Canada and most of western Europe, health insurance should be divorced from employment to avoid coverage disruptions at the time of illness. Insurance policies should incorporate comprehensive stop-loss provisions, closing coverage loopholes that expose insured families to unaffordable out-of-pocket costs. Additionally, improved programs are needed to replace breadwinners' incomes when they are disabled or must care for a loved one. The low rate of medical bankruptcy in Canada suggests that better medical and social insurance could greatly ameliorate this problem in the United States.[22]

In 1591 Pope Gregory XIV fell gravely ill. His doctors prescribed pulverized gold and gems. According to legend, the resulting depletion of the papal treasury is reflected in his unadorned plaster sarcophagus in St. Peter's Basilica.[23] Four centuries later, solidly middle-class Americans still face impoverishment following a serious illness.

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12. The districts were California (Central District); Illinois (Northern District); Pennsylvania (Eastern District); Tennessee (Middle District); and Texas (Northern District). These were chosen to achieve geographic, social, and legal diversity. Together the five districts accounted for 13.8 percent of total U.S. bankruptcy filings in 2001.
13. The 521 extra homeowner cases make the full sample of 1,771 less representative of filers nationally than our core sample of 1,250. Therefore, we used weighting procedures to adjust for the oversampling of debtors in three districts, homeowners, and debtors filing under Chapter 13. The weighted and unweighted findings were little different.
14. Interviews with trustees indicate that response rates in the five districts varied from approximately 55 percent to nearly 100 percent.
15. It proved difficult to contact some debtors, presumably because they were experiencing major life disruptions or were afraid of calls from creditors. After ten unsuccessful attempts to telephone potential subjects, we attempted to reach them through contacts they had previously given us and via a letter. Relative to the overall sample, the 931 interviewed debtors were slightly less likely to be male, to have lost a home, or to reside outside of Illinois but did not differ in age, occupational prestige score, education, or home ownership. On occupational prestige scores, see NORC, "Occupational Prestige Studies/Summary," cloud9.norc.uchicago.edu/faqs/prestige.htm (13 December 2004).
16. Uncontrolled gambling is classified as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV) and contributed to about 1 percent of the bankruptcies.
17. Our Chapter 7 filers are similar to those nationally in income, home ownership, family size, age distribution, and marital status. See E. Flynn et al., "Bankruptcy by the Numbers," *ABI Journal* 20, no. 10 (2002): 28–29; 21, no. 3 (2002): 22, 49; and 20, no. 8 (2001): 20.
18. We achieved high response rates to our initial questionnaire, and rates of medical bankruptcy varied little between districts despite some variation in response rates. It seems plausible that more-stigmatized causes of bankruptcy (such as addiction, mental illness, or profligate spending) may be underreported.
19. Twelve percent of households reported unpaid medical debts in 1997, with 691,000 households reporting outstanding medical debts greater than $5,000. SMR Research Corporation, *The New Bankruptcy Epidemic* (Hackettstown, N.J.: SMR, 2001), 127. A high incidence of collection agency calls was reported in NPR/Kaiser et al., "National Survey on Health Care"; May et al., *Tough Trade-Offs*; and Collins et al., *The Affordability Crisis.*
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22. Between 7.1 percent and 14.3 percent of Canadian bankruptcies are attributable to "health/misfortune." See J.S. Ziegel, "A Canadian Perspective," *Texas Law Review* 79, no. 5 (2001): 241–256.
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Chairman CONYERS. Thank you so much.

I want to thank all of the witnesses. This has been very important. It has caused Chris Cannon and myself to begin to think about ways that we can come together to put some of the corrections that are so badly needed.

And before I recognize him, I just wanted everyone to know that Tim Carpenter from Massachusetts is at this hearing. And the head of Healthcare-NOW, Marilyn Clement from New York, is at this hearing and, of course, Courtney Farr from the California Nurses Association.

And Members of the Committee, all of those folks with the red jackets on are members of the Nurses Association, except Courtney Farr. She decided to wear white today.

And so, I am pleased now to turn these proceedings over to Mr. Chris Cannon.

Mr. CANNON. Thank you, Mr. Chairman.

One of the pleasures of working on this Committee is that the Chairman is very clear in his views of the world and his principles, as am I. We differ on many of those, but being clear means you can actually work together. So he is not exaggerating when he says that there are things we would like to do.

And, frankly, you know, I started out thinking about how Ms. Smith was really the only interesting witness. And, of course, we had people to her right who made that clear. And the people to the left actually were interesting.

There was some humor in the process. The guys to the right—we actually appreciate your information because it will go in the report to some degree.

But I am going to ask the Chair's indulgence here to actually move away just a little bit and then talk about H.R. 676.

And I think, if you wouldn't mind, Ms. Smith—in fact, let me just quote Mr. Rukavina, who pointed out that much of what he and his organization has learned has been talking to people like you. I suspect that by talking about—I know this is very difficult for you. I apologize in advance. Let me just say many of us have had really rotten experiences with the medical system. So I realize it is a little bit difficult.

But I would actually like to talk through with you some of the problems of what happened to you and why and try and inform the larger debate that we are going through here because while it is true that people take money from various different sources and certainly, pharmaceutical companies and others, the American Medical Association, give a lot of money, the fact is they don't buy loyalty, by any means.

And the concern that we haven't done anything, I think, is unfortunate. I don't see it as a matter of shame. I see it as a very complex problem. And I hope that by walking through some of the things that have happened to you we can help inform that debate.

And so, going through your story, "Brewing in my husband's body were bad arteries that also plagued his father." So we start off with a genetic problem.

This is not a problem of—I think, Dr. Himmelstein, you talked about diabetes several times. Actually, several people did. At least

Type II Diabetes is often self-inflicted by people who indulge themselves.

And, in fact, Mr. Conyers, you said earlier that you believe that health care is a human right for everybody. And I have done a little poll of doctors. So this is not scientific, not something I should be criticized on.

But their conclusion, generally speaking, when I talk to doctors—I have done numbers of these—is that 75 percent of our health care costs are self-inflicted. If people would take care of diabetes, if they wouldn't smoke, if they wouldn't drink to excess, if they would eat reasonably, if they would exercise, perhaps as much as 75 percent of our health care costs would disappear. If that happened, then we could afford not only to take care of everybody in America, but everybody in the world and help them have the kind of health care that I think human beings are entitled to, largely through their own responsibility.

But in the case of your husband, he did not have—this is not a problem that he inflicted upon himself. This is a problem that was largely genetic, I take it.

Ms. SMITH. That is correct. Even the doctors at Mayo Clinic talked about the genetic predisposition for his family to coronary and peripheral artery disease. Throughout his body his arteries are not great.

He has, for whatever reason, the cholesterol-making capacities that are in high gear and deposit cholesterol throughout. And he is sitting right behind me, always been a tall—this is my husband, Larry, sitting right here—tall, slender man.

And if you looked at the two of us and wanted to decide which one might be plagued by some problems with heart issues, it might be me who tends to overeat occasionally and have problems with things I shouldn't do. He has always been a very active, tall, slender guy.

Mr. CANNON. I am neither tall nor slender, but I am blessed with wonderful cholesterol.

Ms. SMITH. That is all——

Mr. CANNON. With the other burdens I carry through life, that is just—it happens genetically. And you, on the other hand, had uterine cancer.

Ms. SMITH. That is correct.

Mr. CANNON. Geez, the time is just not long enough to deal with these issues. I am frustrated because the time is almost gone.

But your disease was not something you inflicted upon yourself through lifestyle. It is either genetic or something in the environment that affected you. So there is really nothing you—you are not like an overeating person that brings on diabetes and smokes and drinks and causes huge costs in our health care system. You really are a typical, normal middle-class American who was smashed in a system.

Ms. SMITH. Yes. I would like to just—I know this is really an aside. But one of the other things for me because Larry was having so many significant health problems and I was so worried about the $60 it would cost me to go to the doctor, I put off going, even though I knew there probably was something going on with me. I

wrote it off to this must be pre-menopausal system—it must be something else and waited.

And then I had a cancer diagnosis. And I would like to urge every woman, whether she is here or listening somehow, even if it is $60, go get checked.

Mr. CANNON. You know, we held a hearing in Government Reform on that topic. And I think we actually passed that bill that encourages public awareness of uterine and other female cancers for that very reason.

Ms. SMITH. Absolutely.

Mr. CANNON. And, in fact, your point—I am just going to follow up. You point out that Larry's surgery was botched. And on the other hand, you refer to, I think, the intuition, I think you refer to, of your doctor who sent you to an OBGYN.

Ms. SMITH. Absolutely. It was a dichotomy for us. His surgery——

Mr. CANNON. You sort of got blessed.

Ms. SMITH. I was blessed with a nurse practitioner who was——

Mr. CANNON. Yes.

Ms. SMITH [continuing]. Who was ready to write me a script for hormonal therapy thinking that I was having pre-menopausal symptoms at the age of 45 or 46. And she was ready to write that script. And she stopped and turned around and said, "I just don't like the sound of this."

And I said, "What would you do if it was you." She said, "I would go have a D&C done." I said, "Well then, that is what we have to do, if I can get it paid for." And fortunately, my insurance company said yes. And thank God, or I might not be sitting here today to testify.

Mr. CANNON. Mr. Chairman, my time is expired. Can I make one short comment? And then if we have a second round, I would like to pursue this topic.

That is we have a doctor in the InterMountain Health Care System named Brent James who has done some really interesting things in particular that go to helping avoid botched operations and intuition, which is helpful on occasion. But if somebody is only riding on intuition, we are likely to see serious other kinds of problems. And that, I think, is one of the areas where we will agree that there is terrific opportunity for progress.

And with that, I yield back hoping that we will have a second round.

Chairman CONYERS. Thanks, Chris Cannon.

Let me review my notes here.

A 2-year wait for Medicare—who made that statement?

Ms. SMITH. That was my husband. When he applied—that is what the law is right now.

Chairman CONYERS. Now, that is something the Congress can do between your Committee, other Committee, and this Committee, and Ways and Means Committee, we want to take care of that.

Then somebody talked about a long wait to even get to bankruptcy after you file. Was that Attorney Warren?

Ms. WARREN. I was the one who mentioned that one of the important changes in the recent bankruptcy amendment was to lengthen the time between bankruptcies, how soon a family could

file again. And that for families with medical problems, we have to remember one of the reasons that bankruptcy is not a solution is that the medical bills continue.

You know, I hate to say this. But the advice that I am often called on to give for families facing serious medical problems is wait until you are sure that the medical problem is entirely over. And frankly, that may mean the death of whoever is seriously ill before it is that you file for bankruptcy because once you file, there is a minimum of 6 years before you will be able to come back again, no matter how serious your problem and no matter what the reason is.

Mr. CANNON. And, Mr. Chairman, would you yield just for the clarification of that? In the BAPCPA—really, we should have put another noun in there. Did we lengthen the time between the filings for insurance, do you recall?

Ms. WARREN. I thought you had. Although I am willing to yield in the—Professor Zywicki, have I got this wrong?

Mr. WHITE. There is a time between discharge that goes from six to eight, if I may, Mr. Cannon.

Ms. WARREN. Yes, we added 2 years.

Mr. WHITE. But the basic issue with regard to if one has an ongoing substantial debt situation that was something pre-BAPCPA or post-BAPCPA that would have existed in the bankruptcy system going back from decades.

Ms. WARREN. Right. But basically——

Chairman CONYERS. Yes, that is 6 to 8 years——

Ms. WARREN. That is right.

Chairman CONYERS [continuing]. Before the date of the filing of the petition.

Ms. WARREN. That is right. An increase of 2 additional years for families who are hard-pressed and regardless of the reason.

Chairman CONYERS. Two years.

Mr. Rukavina, you made suggestions about what insurance companies might be able to do to make this system a little bit more palatable. And we want to put that into the record that you can elaborate on it whenever you want. But just note that this Committee wants to get some specifics from you on that.

Now, it just occurred to me I was thinking that a lot of people are too embarrassed, they are too proud to go into bankruptcy. Bankruptcy used to be something that you don't tell the neighbors about. I am beginning to think it has become so common now that that stigma is wearing off.

But one thing isn't wearing and accounts for why people don't file is that they might lose their jobs when their employers find out that you have gone into bankruptcy. Is that correct? Some people say yes.

Professor Zywicki says no. I yield.

Mr. ZYWICKI. Under Section 525 of the Code, you don't lose your job if you file bankruptcy.

Chairman CONYERS. Well, what if you get fired and then you tell your employer that under Section 525 of the Code that you don't lose your job?

Ms. SMITH. Representative Conyers, I would like to mention, too, from someone who had to move from South Dakota to Denver,

many employers now do a credit check to find out whether or not they want to hire you as an employee. So they now make a decision on me whether or not they want to employ a woman who would work very hard for them and do a lot of good for their company or their organization based on the fact that I got sick and my husband got sick and we declared bankruptcy.

Chairman CONYERS. I hold in my hand 21 forms that are required to be filled out now. The very first one contains 57 questions dealing with means test calculation. The other is a voluntary petition. The next one, list of creditors holding the 20 largest unsecured claims, a summary of schedules for the bankruptcy court itself, statistical summary of certain liabilities and related data referencing 28 United States Code Section 159, real property.

This is just to get into the bankruptcy door. Now, we have to examine one very important thing before we leave here today. Is it convenient, or is it as smooth as some of my friends here at the witness table have alluded? Or is this a burdensome administrative chore, daunting, maybe stress-inducing?

I mean, you have to really want to do something real bad to fill out all of this stuff. Even though you don't want to go into bankruptcy, but this is what you have got to do.

What do you say, Professor Warren?

Ms. WARREN. Congressman, what has happened is that with the 2005 amendment we have simply driven up the cost of filing for bankruptcy. The attorneys fees have gone up.

Chairman CONYERS. That is right.

Ms. WARREN. The length of time, the schedules, the information that a debtor has to bring. You generously do not read some of the questions that are there. They are not only impossible for most ordinary families to understand, frankly, they are impossible for many lawyers to understand, even though specializing in the field.

When we drive up the cost of filing for bankruptcy, we don't drive them up just for those who abuse the system. We drive them up for every single family. We drive them up for Ms. Smith and her husband, everyone has got a medical problem, everyone who has lost a job, every single mother who has had somebody walk out and leave her with $50,000 worth of debt.

We have taken a system that was inadequate to deal with the fallout from our health care system and we have taken that bankruptcy system and we have made it more expensive, narrowed the doors and made it an even less useful remedy for families that are in serious financial trouble.

Chairman CONYERS. Dr. Himmelstein, there is this concept in the civil rights movement that civil rights organizations are now looking at human rights. They kind of expanded from what the NAACP when it started in 1909.

But is health care now being re-examined by doctors and the AMA and health care providers and nurses and professional people in the industry and teachers? Is health care being examined as a basic human right that ought to be available, certainly to everybody in this country? And if so, is that concept growing, or are things getting worse?

Mr. HIMMELSTEIN. I will address that in two ways. One is to say that, of course, the U.N. declaration of human rights includes

health care as one of the fundamental human rights. And the rest of the developed world has already recognized that as one of the fundamental human rights that is an entitlement of everybody in those other Nations.

If you ask Americans that question—and it has been asked by many polling organizations over the years—the American people are overwhelmingly in accord with that concept as well. I ask this of my medical students in a very specific way.

I say to them our bank that was robbed in Harvard Square some few years ago—one of the bank robbers was accosted shortly after leaving the bank and shot. And I asked them do you believe that he should have been cared for for his wounds. And I have yet to find a student who says that we should have left that bank robber to die on the streets of Cambridge.

And what I then ask them is if a bank robber who has just robbed $50,000 from our local bank should be entitled to medical care, should we then deny that to a child with leukemia in our city. Should we deny it to an elderly person with high blood pressure? So I think by every standard in the civilized world today we should, and most of the world does, recognize this as a fundamental human right.

Chairman CONYERS. But does that mean we have more work to do in this country to get more people to recognize it?

Mr. HIMMELSTEIN. Well, the Institute of Medicine of the National Academy of Sciences tells us that at least 18,000 adults die each year because they cannot access medical care because they have no health insurance. So we are a long way from recognizing this as a human right. In fact, we have the number of deaths of 9/11 every 2 months in this country from lack of health insurance. And yet, we take that as a commonplace and have done nothing about it for a generation.

Chairman CONYERS. The gentleman from Arizona, Trent Franks?

Mr. FRANKS. Well, thank you, Mr. Chairman.

And thank all of you for coming to testify today.

Mr. Chairman, I might start out by just saying how deeply I sympathize with people who have medical challenges. I have the memory of being a child born with some significant—I don't remember when I was born, but dealing with some of the significant issues of being born with full cleft. And this was devastating to my family as far as the costs and things associated with that.

And so, I want you to know that my sympathies are there and very sincere and very real.

That said, I was reading the other day, Mr. Chairman, about a new process by which they inject a substance into a cancer patient. And this substance goes into every cell in the body within about 48 hours, even passes the blood/brain barrier, goes into the spinal areas. And essentially it is present in some form of some concentration in every cell in the body.

And then they leave it for another 48 hours or so, and it dissipates in all of those cells, completely leaves, except in cancer cells where it is retained. And then they subject the patient to a certain bright light. Now, this is certainly experimental. It is just hopeful that this is going to occur.

And that light turns that substance poison and kills only, only the cancer cells in a person's body. In other words, it would be a fundamental cure for almost all types of cancer. And the hard cost would be $2,000 or $3,000 once it is done in the long run.

That kind of innovation is a byproduct of a competitive system in America that has given us the most effective health care system, I believe, in the world. And today there has been a lot of discussion on national health care with very little on bankruptcy reform. And I am afraid that we are trying to make bankruptcy reform deal with a fundamental issue that is not really bankruptcy-related.

And I think the challenge here, what we all want to do is to make health care and all of these innovations and all of these things that can give people the qualify of life that we so desperately want to give to all of God's children available and accessible in as cost-effective way as possible. And if one just glances at history in the background a little bit, the highway of history is littered with the wreckages of Nations who thought that they could manage productivity and innovation, the governments that thought that they could do that better than the market and the private sector and the free enterprise mechanism.

And I hope that we don't make this problem far worse by nationalizing health care. I can't think of a worse thing that we could do to patients that are in a crisis situation than taking away the innovation that has the potential someday to deal with all these things.

Much of the advantages that we have today are because our free enterprise mechanism has given us such innovations. And I think that nationalized health care would be the ultimate destruction of innovation in America in terms of health care innovations. And without those innovations, with the growing health care crisis and the growing issues that are related to it, it occurs to me that it is going to be hard to meet that circumstance in any frame unless we come up with some major innovations, especially with the top five killers.

And those are, you know, like cancer and heart disease and diabetes and such. I think we need major innovations in those areas or we are going to have a very difficult time as an American family and certainly as even a human family in dealing with these in the long run.

With that said, it kind of gives you the direction I am going in. I just think that nationalized health care is a terrible way to handle this issue. I think it will make the—if you think health care is expensive now, wait until it is free.

With that, Professor—I am going to have a hard time—Zywicki, could you give me some idea of your own opinion that what negative or perverse economic consequences for health care in bankruptcy systems are of trying to solve a medical debt bankruptcy crisis through the institution of national health care? Do you think national health care is the way to solve a bankruptcy issue?

Mr. ZYWICKI. Congressman, I share your concern and all those here about the percentage, you know, the people who are hurt, who are unable to pay their substantial health care bills today. I can't imagine how you could hook those two up.

It just seems to me that for precisely the reasons that you describe what we are talking about here are a relatively small num-

ber of people who have very serious problems. The bankruptcy system today deals with those situations quite adequately, not perfectly. But no system is perfect.

I think that to try to solve that particular problem through the bankruptcy system would not only interfere with the smooth functioning of the bankruptcy system, but, as you just suggested, might have very serious unintended consequences for health care affordability and availability as well.

Mr. FRANKS. Mr. Chairman, my time is expired. Might I just add the comment that I am afraid that national health care would have the compassion of the IRS, the efficiency of the post office before we increased its competition, and the cost of the Pentagon.

So thank you very much.

Chairman CONYERS. Thank you.

Would the gentleman allow me to grant him an additional couple of minutes so that Dr. David Himmelstein can comment on one his comments?

Mr. FRANKS. Certainly. I am sure he has a perspective.

Mr. HIMMELSTEIN. Well, the issue of medical innovation and the national health insurance system is one particularly close to my heart. My father was the surgeon on the team that developed cardiac catheterization that won the Nobel Prize for that innovation in 1956. It was a team funded by the National Institutes of Health.

And virtually every major medical advance of the last 50 years has been, in fact, funded by the National Institutes of Health. And we are now facing a crisis in medical innovation in our country with the drug companies having adopted a commercialized drug development process, which is now yielding a distressing paucity of innovation in that field. We are told, in fact, there is even a commercial crisis of the drug industry because they are not developing important new drugs at a reasonable rate for their investors and concern that drug stocks may be falling because of it.

So we, in fact, have very substantial evidence that innovation in medical science the public sector is an extraordinary leader. And we also have that from real world experience. I mean, insulin is, of course, a development from Canada. The C.T. scanner comes from the United Kingdom, the angioplasty, which is the product of a German physician, all of those places with national health insurance.

And while we have a superb cadre of scientists in this country—and I certainly would defend my colleagues medical and scientific excellence—the process that we now have in place is clearly beginning to stunt the development of medical science, not further it.

And in terms of cost, it is very clear that our privatized health care system is by far the most costly and least efficient in the world. We spend nearly twice per person what Canada does, and a good deal of that excess spending is on the bureaucracy needed to keep our private health insurance in place.

Just to give you one example, more people work for Blue Cross Blue Shield in my home State that insures 2.5 million people than work for the entire Canadian national health insurance system that insures 30 million people.

So with due respect, Mr. Franks, I do think that we would be both furthering innovation and efficiency in moving to national

health insurance. And I would respond to your concerns about the IRS and the post office, that if we had a post office that was like our health insurance company, they would be saying to us things like we are not going to deliver you the mail. You are too far from the post office or get too many packages.

Mr. FRANKS. They do that in my district sometimes.

Mr. Chairman, the only thing I could add to that, in all sincerity to the gentleman, I appreciate his comments. But I do think that the case is very strong that those areas and those nations who have at least a modicum of enterprise and free market system clearly outpace those in innovation that do not. Otherwise, I just don't think Canadians would come here for heart operations. They would stay there.

Chairman CONYERS. Well, I can tell you, sir, that I met Americans in Canada when I was holding hearings who were told by their doctors to go to Canada because there was no way that they could be accommodated under our health care system.

Mr. HIMMELSTEIN. Indeed, a few years back a Member of Congress went to Canada for his medical care because the leading specialist in that unusual lung disease were, in fact, in Toronto. And when Paul Tsongas was running for president some years ago, he expressed his concern that he wouldn't have gotten the bone marrow transplant that he believed lengthened his life, which was a surprise to the doctors in Toronto who developed that procedure and who do it in larger numbers per capita than we do in Boston.

Chairman CONYERS. The distinguished gentleman from Georgia, Hank Johnson?

Mr. JOHNSON. Thank you, Mr. Chairman.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 was indeed a misnomer. It probably should have been named the Creditor Relief Act of 2005.

And I say that because it made it more difficult for consumers to obtain bankruptcy relief, either Chapter 7 or Chapter 13. And it acted to protect the creditors who many times were credit card issuers. And those were the primary lobbyists seeking a change in the bankruptcy laws at the time.

There were not consumers down here in hoards saying that we need consumer protection and abuse protection under the Bankruptcy Act. It was the creditor, i.e., the credit card issuing companies.

And with that in mind, Mr. Zywicki, I would like to find out whether or not you know that in the schedules that people file for bankruptcy relief that the Chairman displayed the voluminous copy of that lists so many details of the person's life—but one of the things that is listed is the creditors, information about creditors. And so, you list the types of creditors. It could be a second mortgage on the home. Or it could be voluminous or an outrageous amount for credit cards.

When you did your study in determining that medical debt was not really a major causal factor in bankruptcy filings, did you take into consideration that sometimes people borrowed money on their houses and on credit cards and paid the medical debts with those and then declared bankruptcy on the debt that was owed on the credit card or on the second mortgage?

Mr. ZYWICKI. Thank you, Congressman. That is a very good question that goes to the difficulties of trying to untangle what exactly the medical bankruptcy——

Mr. JOHNSON. Now, when you start dancing on me instead of answering the question it makes me think that perhaps the answer is no.

Mr. ZYWICKI. Well, the reason why it is difficult is because different variables cut different ways. So, for instance, you are exactly right. Some of the debt that people incur with respect to medical expenses are for credit cards, or home equity loans, that sort of thing.

On the other hand——

Mr. JOHNSON. Well, there was no way of in your study of differentiating between what portion of the credit card debt and second mortgage——

Mr. ZYWICKI. That is correct. What I have been trying to say is——

Mr. JOHNSON. It is either medical or——

Mr. ZYWICKI [continuing]. A summary of other people's studies. I have not done an independent study. I have looked at the United States trustee study, which I commend is a very good study. I have looked at other studies that have been done through the years. All of them note this particular problem.

On the other hand, you have got other difficulties. So, for instance, medical debt is typically unsecured debt, which is dischargeable in bankruptcies. So what we also know—and if you talk to any lawyers, what you know is that in the period preceding bankruptcy, people will pay down non-dischargeable debt or secured debt like their mortgage and choose not to pay debt that is dischargeable in bankruptcies.

So that is——

Mr. JOHNSON. But you have caught them both ways on——

Mr. ZYWICKI [continuing]. Cuts both ways.

Mr. JOHNSON [continuing]. The bankruptcy, though. Chapter 7 made it more difficult for the straight discharge. And Chapter 13 made it more expensive, you have got more paperwork to fill out. The filing fees are higher, just a more onerous burden on people to file Chapter 13s as well, so hitting them both ways.

And is there any way that you can point to a cost reduction for the creditors because of the burdens, the increased burdens that were put on the consumers in filing Chapter 7 and Chapter 13? In other words, has it saved or made money for the creditors?

Mr. ZYWICKI. Sure. What we know——

Mr. JOHNSON. Is that yes or a no?

Mr. ZYWICKI. Empirical studies support exactly what economic theory suggests.

Mr. JOHNSON. Well, is that yes or no?

Mr. ZYWICKI. Which is that the more risky lending is, the more—all consumers have to pay for credit.

Mr. JOHNSON. So is your answer that the creditors have made off like bandits while the consumers have been left with the surgical robe that Dr. Himmelstein pointed to and the Vaseline on the table next door? I mean, that is—I mean, your backside is definitely showing, I think, throughout all of this.

Mr. ZYWICKI. I have not seen any evidence that indicates that at this time.

Mr. JOHNSON. That indicates the use of Vaseline. Thank you.

Chairman CONYERS. The Committee will stand in recess until we have disposed of the votes that summon us to the floor.

[Recess.]

Chairman CONYERS. Will the witnesses take their seats so that we can conclude this hearing?

The Chair sees no other Members present in the chambers. And he would like—wait a minute. We do have Jim Jordan of Florida, who said he would be back. And he is back. And he will be our final witness interrogating—distinguished Member of the Judiciary Committee is recognized.

Ohio—I stand corrected.

Mr. JORDAN. That is right.

And let me just ask a question. Let me get your response, too. Does the United States of America have the best health care in the world, not health care financing, but health care?

We will start at this end and maybe just—I am just kind of curious. And I apologize. I was not here for your testimony. I apologize—the meeting. But go ahead and respond.

And we can start with the professor.

Mr. ZYWICKI. It seems that way to me.

Ms. SMITH. I do not know the answer to that 100 percent. I know that I received some fine care when I went to Cuba with Michael Moore's staff. I know that I have received some wonderful care here, as has my husband received some wonderful care here in the United States. But because I am just an average American, I haven't traveled everywhere to compare every system.

Mr. JORDAN. Well, I understand. But as an average American—I mean, frankly, we politicians should listen to average Americans a little more often, I think, than other folks.

Ms. SMITH. I would agree.

Mr. JORDAN. But just if you just had to like just hazard a guess.

Ms. SMITH. I would say—I have chatted with Senator Tom Daschle about this not long ago. And he said he would describe our system as islands of excellence in a sea of mediocrity.

And I think that I have been—I think that my husband has been blessed, I will say that, in seeing some of those islands of excellence in his care, or he would not be alive today. So I believe we have some outstanding doctors and facilities and care providers in this Nation.

Do we have the best in the world? I think we could. I think we have a great start on that. But I think we have some trouble with infant mortality rates and some other things that we really need to work on.

Mr. JORDAN. Professor Warren?

Ms. WARREN. I would say it is excellent for those who receive it. But it is certainly not excellent for those who are closed out of the system.

Mr. JORDAN. Let me just ask a quick follow-up then of you.

Ms. WARREN. Sure.

Mr. JORDAN. Who is closed out of the system?

Ms. WARREN. Well——

Mr. JORDAN. I mean—and I don't mean that to sound, you know,——

Ms. WARREN. No.

Mr. JORDAN [continuing]. Trite or anything. I am just—you know, because I don't know of anyone who ultimately is denied care. It could be a hassle. And we have heard the compelling story from the lady beside you.

But who ultimately is denied care in the——

Ms. WARREN. Well, it is basically two groups that are denied care. It is those who have no health insurance and cannot pay and actually are denied care. It is also those who are so deeply ashamed that they cannot pay for their health care who are in debt and who won't go back to the doctors.

Mr. JORDAN. Okay.

Ms. WARREN. And I should add remember the details of Ms. Smith's story. Part of it was that her husband could not receive follow-up care because although the Mayo Clinic—we can name one of the finest health care institutions in this country—said we will give the care, we have forgiven the debt. But if you ever plan to come back and get any follow-up, come with—was it $6,000 cash—in your pocket.

Mr. JORDAN. Okay.

Ms. SMITH. They told us whatever our portion would be we needed to bring cash first.

Ms. WARREN. I call that denial of health care.

Mr. JORDAN. Let me move to the next—next to you.

Go ahead.

Mr. RUKAVINA. I live in Boston. And we have some of the finest medical institutions in the world. I am happy to live there. And I agree with Professor Warren. I think there is uneven access to care in the United States.

Mr. JORDAN. Okay.

Mr. RUKAVINA. And we have done studies. Others have done studies.

Mr. JORDAN. Okay.

Mr. RUKAVINA. Individuals with medical debt, a significant number of them have been asked to pay before they are able to schedule a follow-up visit with a provider.

Mr. JORDAN. Doctor?

Mr. HIMMELSTEIN. It is a topic that has concerned me for many years from the time that I was an intern and did the first study of so-called patient dumping in this country in 1981 and found that about 300,000 Americans are denied care in emergency rooms in hospitals each year because they can't pay for it, clearly, sub-standard care. We also have a substantial population that financial incentives in our system—excuse me—give doctors and hospitals incentives for excessive and often even assaultive care so we know that something like 70 percent of the stints put in in this country do our patients no good and may actually harm them.

The systematic answer I would give you is my colleagues and I published this spring a study looking at every study ever published comparing quality of care in U.S. and in Canada. And what we did was we searched the world's literature, queried not only computer databases, but colleagues to come up with every study ever pub-

lished. We then had a librarian go through and blackout the results of each study so that we could not tell which had favored U.S. or Canada before deciding whether the study should be included in our systematic analysis.

We then summarized all of the evidence. And the best evidence comparing insured Americans with the average Canadian is the death rates are about 5 percent lower. Mortality rates are about 5 percent lower in Canada than in the U.S. for patients with comparable illnesses treated in Canadian as compared to U.S. care.

Statistically that is not a significant difference, we thought. So we said indistinguishable though the trend favors Canada. And I think that that probably comes from what was referred to as islands of excellence in a sea of mediocrity in the U.S. But I hasten to add that virtually all of those studies in the U.S. situation were of insured patients and excluded those who were receiving the most sub-standard care.

So I would say the fairest answer to your question is if you are insured in the U.S., you get care about comparable to that of the average Canadian. If you are uninsured, the quality of your care is substantially worse in the U.S.

Mr. JORDAN. Mr. Chairman, it took a little longer to get through that with six panelists than I anticipated. But I see my time is expired.

Chairman CONYERS. Thank you, Jim Jordan of Ohio.

Mr. JORDAN. Yes, there we go.

Chairman CONYERS. We appreciate it.

Ladies and gentlemen, this has been very instructive. I would like to leave the panel—well, let me ask Professor Zywicki: What have you learned? What do you recommend? Where do we go from here, the Committee, if you wanted to give us some free advice?

Mr. ZYWICKI. With respect to bankruptcy?

Chairman CONYERS. Yes.

Mr. ZYWICKI. With respect to bankruptcy, as I said, the fundamental challenge is balancing the needs of innocent individual debtors with the needs of those doctors and hospitals that provide health care service. And they are innocent, too. And I believe that the current system balances those interests appropriately based on what we know today.

BAPCPA has only been in effect for less than 2 years. It may be that future real data comes up that tells us that this is a serious problem. For the time being, though, it seems to me that it is a complicated balance, but it seems to me, it strikes the balance between those two innocent groups of people with respect to bankruptcy. So I don't see any need to change the bankruptcy system right now.

Chairman CONYERS. Thank you. And you do not feel that the 21 different forms that I am putting into the record, which total into hundreds of questions of some detail, don't need some scrutiny and review and reduction?

Mr. ZYWICKI. Well, Congressman, I think that we need to continue studying how BAPCPA is actually working. This body looked at BAPCPA for 7, 8 years before it went into effect. There was one clear lesson we learned from that, which is that we tried the honor system with respect to bankruptcy.

We tried a system with few safeguards, few tools for studying fraud, looking for fraud and abuse and that sort of thing. And it turns out, human nature being what it is, that the honor system didn't work, just like it wouldn't work if we had a tax system without an IRS. We could say pay as much tax as you want, and we know that wouldn't work.

We found that that was going on with bankruptcy. So we tried to—this body tried to put in safeguards, tried to put in mechanisms to increase the accountability and the protections against fraud and abuse. And I think that it is absolutely imperative that this body continue to look at whether or not we have struck the right balance, whether or not the system is working as intended to try to ferret out fraud and abuse while preserving the fresh start for those who need it.

So far from what I can tell, the system seems to have struck the—BAPCPA seems to have struck the right balance. Although around the margins, obviously, with respect to things like credit counseling, for instance, we may want to look and see whether or not it has been a cost effective reform from a cost-benefit analysis.

Chairman CONYERS. Does your memory go back far enough to recall how long the credit card companies had campaigned for bankruptcy reform? I have been here several decades, so I remember. Do you?

Mr. ZYWICKI. I don't. I didn't really pay that much attention to the lobbyists. I mean, I haven't received—my research is not sponsored by any consumer creditors.

Chairman CONYERS. I see.

Mr. ZYWICKI. I haven't received a dime from any bankruptcy groups like bankruptcy judges or any of those sorts of people who think that—who want more bankruptcies. I am just, you know, an independent professor who thought that the bankruptcy system could use some reform. And so, I didn't really pay attention to——

Chairman CONYERS. But it didn't come to your attention as a professor or as a citizen?

Mr. ZYWICKI. Sure, absolutely. Yes, Congressman. I mean, when I said there were——

Chairman CONYERS. I mean, you know what I know about how we got to the law.

Mr. ZYWICKI. Absolutely. What I saw was there were a lot of—there were consumer creditors who wanted reform. There were a lot of bankruptcy lawyers and members of the bankruptcy industry who spent a lot of money and flying around here all the time trying to lobby against them.

Chairman CONYERS. Year after year.

Mr. ZYWICKI. So——

Chairman CONYERS. Exactly. Okay. Now your memory is coming back.

Mr. ZYWICKI. Right. So special interests lobbying on both sides. And, you know, I don't know—the final result, according to at least the empirical studies I have seen suggested that congressmen and senators voted for or against bankruptcy reform based on whether or not they thought it was good or bad policy, not based on special interest influence.

And that was my impression, that those who voted against it did so sincerely. Those who supported it in this House did so sincerely. And I see no reason to doubt that.

Chairman CONYERS. Mr. Jordan? I yield to the gentleman.

Mr. JORDAN. Thank you. If I could, Mr. Chairman. I appreciate you yielding.

Just one question for Professor. You know, last week I met with a group of doctors in our district. And, you know, they would all agree with, I think, your assessment, which they believe we have the finest health care system in the world. And I know the panel was mixed on that.

But they would agree with that. But they are very frustrated with the financing system. I mean, so much so that a few of them—the majority said no. But a few of them were saying single payer, government-run system can't be worse than dealing with the insurance companies like we are dealing with today.

I mean, I am very nervous about going in that direction. I think Congressman Franks when he talked about the government running and making decisions about health care—I think it is a scary thought. And I am certainly not for it.

But I was somewhat surprised at the frustration from providers. I mean, great doctor, surgeon, everything. And I related to them it seems to me every single health care decision you have got so many players in the game: the doctor, the patient, the insurance company, the employer, the government, the pharmacist, the pharmacy benefit manager, and the band plays on.

And the complication of the whole—and I know this is a longer thing. But just real quick, what is it, in a general thing? And I know this is off the bankruptcy topic. But I am searching for where we have to go to make it work better, the best system. And, you know, that is a huge question at the end of a Committee hearing, I understand. But it is what I wanted to try to get to. And I appreciate the——

Chairman CONYERS. But a very appropriate one, sir.

Mr. ZYWICKI. I agree. I mean, I don't have any particular answers, other than that I can restate the question as a bankruptcy question, which is one that I am more familiar with. And this isn't directly on health care.

But when I was working on the bankruptcy reform legislation and being involved in that process, at one meeting I sat down next to a fellow who ran a—a father and a son who ran a small, family-owned lumber store in Southern New Jersey. And I said, "I don't understand. Why are you here? Why do you want bankruptcy reform?"

And he said, "Well, listen, Professor, it is this simple. Two years ago, a Home Depot opened up in the next town over, and we are already having trouble making ends meet. So let me tell you, somebody comes in, and, you know, we give them a credit to borrow $1,000 to build a deck or something. The next thing you know, they file bankruptcy, and we don't see any of that money."

"And let me tell you it is hard enough to make ends meet competing against a store like Home Depot to not have to deal with $1,000 or $5,000 or $10,000 or $20,000 or $30,000 of bankruptcy

losses every year. And that is why we want bankruptcy reform." That is a small-business man.

I suspect and, you know, my observation is that a lot of doctors, for instance, are fundamentally small-business people. And we have heard today that for one reason or another, a lot of medical bills are not paid either because they can't be paid or they aren't paid. And I can understand why a health care provider, for instance, may want to get rid of the complexity of trying to collect on bills, may want to get rid of the risk of not being able to collect on bills.

You know, if somebody discharges $50,000 of bills, you know, that could be your bonuses for your salary. I mean, you could imagine sort of where that money goes.

Chairman CONYERS. Right, right.

Mr. ZYWICKI. So one could imagine why health care providers may seek a more secure and a more systematic way of being paid. How to bring that about is not my area of expertise. I can just sort of identify that I understand the problem that he has in mind.

Chairman CONYERS. Could I just ask the witness, who is very articulate, do you believe health care is a human right?

Mr. ZYWICKI. Congressman, I——

Chairman CONYERS. And you can say no if you really don't believe it.

Mr. ZYWICKI. Well, I am trained as an economist.

Chairman CONYERS. Sure.

Mr. ZYWICKI. And I am trained to look at the world through a lens of scarcity. And so——

Chairman CONYERS. Of dollars and cents, cost-benefit.

Mr. ZYWICKI. That there are tradeoffs. And obviously, ideally I would like to have great health care for everyone. I would like to have great education for everyone. I would like to have the safest cars and the safest houses for everyone.

Chairman CONYERS. Right.

Mr. ZYWICKI. Now, there is a lot——

Chairman CONYERS. There is a lot of things that you would like.

Mr. ZYWICKI [continuing]. Of things I would like.

Chairman CONYERS. But the 18,000 people that I have never heard disputed that die because they don't get health care—what do we give them, a cost-benefit analysis? Or——

Mr. ZYWICKI. Well, thank you for allowing me to clarify my observation.

Chairman CONYERS. Sure.

Mr. ZYWICKI. I mean, obviously the tradeoff—I am not an expert in this field, but just as somebody who has followed it loosely as a citizen, the tradeoff seems clear, which is to say that trying to increase access to everybody, it has been argued, leads to rationing, leads to wait lists for people having to wait to see a doctor and that sort of thing.

I personally don't have the expertise to say how we should trade off questions like choice, whether somebody should be able to choose their doctor rather than be assigned a doctor, how long somebody should have to wait to see a doctor for different types of——

Chairman CONYERS. So you assume a universal health care proposal would assign doctors? It would take the private right? And that is one of the things I wanted to get in the record, that universal health care, as is proposed in the Congress, is not government-run. It is privately run, but government financed, which it is a great deal right now. It is just that the systems are not working very well.

Mr. ZYWICKI. Congressman, I present some data in my testimony which is very surprising to me, which is, for instance, the observation that the decline in insured rates seems to be primarily among immigrants. Over the past 13 or 15 years, the insurance rate for natural born Americans has actually risen.

Now, why do I say that now? Well, mainly just because this is obviously, as every congressman who has spoken today has observed, this is a very, very complicated, complex question of how to deliver to people the right combination of choice, quality, cost, and that sort of thing. Obviously, there are a lot of other big social issues wrapped up in there, which may be issues of immigration, for instance.

What the best way to bring that about I will leave to other people to try to decide.

Chairman CONYERS. Thank you so much.

Mr. Clifford White, do you have any parting comment?

Mr. WHITE. Well, the only observation I would make, Mr. Chairman, is that there is no information or data that we have identified that would show that the bankruptcy reform law has had an adverse impact on those who have filed bankruptcy because of high medical debt. So just a couple of factual observations that some of which were in the testimony.

The major change in the bankruptcy law and the consumer law that would potentially affect such filers would be the means test. More than 90 percent of filers are not affected largely by the means test. And of the stack of forms that you pointed to, the large stack of forms, almost all of those forms were required pre-BAPCPA, one major exception being the means test form, which more than 90 percent of the filers just fill out the income portion, the first 15 lines.

So in our observation, the means test is not having an adverse impact. And we understand both in applying the formula to make sure it takes into account health care costs and also in exercising discretion where the form may not take into account job loss, for example, that we exercise discretion in taking into account special circumstances which the law allows us to do so that we do not in our enforcement activities take any steps that are unnecessarily adverse to debtors.

That is a responsibility, a discretion we are given by the Congress. And we have been very energetically trying to carry that out.

Chairman CONYERS. Thank you so very much.

Ms. Smith?

Ms. SMITH. One thing I wanted to—I wanted to thank you first of all, Congressman, for letting me speak as I don't think very many Americans get the opportunity to do what I did here today. And I deeply appreciate that.

I do want to correct just one thing that you said. I don't think that the stigma of bankruptcy is gone at all. I think there is still a huge stigma to bankruptcy, certainly, for any of us who were raised with middle-class values, those of us who were raised to work hard and do the right thing and go to church and be good, faithful members of our communities.

Bankruptcy is failure. Bankruptcy is horrible. And anything that makes that more difficult is hard to imagine that we wouldn't want to remove medical debt from that process.

And the other thing I hope I can say to all of you because I appreciate an economist's point of view, I appreciate a trustee's point of view and all the other people. But I know that if we had to go strictly by the numbers, way back when when we formed this Nation, we never would have fought the War of Independence.

We never would have fought to be in this room today if we went strictly by the numbers and said this is the way it should play out. But we didn't do that because we believed there could be a better way to run government. And I am still going to implore all of you to please listen to the people who elected you and make this a better system for us. Thank you.

Chairman CONYERS. Thank you very much.

Professor Warren?

Ms. WARREN. I will just be very brief and say that I agree that the old system didn't work before the 2005 amendment, not because there was evidence of fraud and abuse. There was never evidence of fraud and abuse. These were stories, frankly, that people just kept repeating.

But the only hard data we had was that there was not substantial fraud and abuse in this system. The reason it didn't work, bankruptcy never was a good substitute for having health care insurance that really worked. It is a poor mismatch.

The reason we see families in bankruptcy in the aftermath of health care problems is because there is no place else for them to go. They didn't turn to bankruptcy because they said, "Man, lucky me, I have got $25,000 in medical debt and so this must be my lucky day. I can file for bankruptcy." It is that they scramble and look.

It is not option two or option 10. It is option 500 on the list of selling your goods and having garage sales and put second mortgages against your house and put a second lien against your car and every other thing you can do to try to scratch to make it to the next pay day without having to go see a lawyer and declare bankruptcy. So we had a system that was broken. Yes, sir, we did. And, frankly, Congress just broke it worse.

They drove up the costs of filing for bankruptcy. They didn't separate out and say we are going to drive up the costs just for families that abuse it. We are going to drive up the costs for everybody. And they made access-tougher, tougher for everyone. We used the 8-year example as just one of those.

So if you ask the question around health care and bankruptcy, I have to say you took a bad system and you made it worse. But I will say one more thing about why it is relevant for this Committee. You are the voice of families like Ms. Smith's, families who

have been forced into this bankruptcy system. You are the voice for the rest of the Congress.

If you will not tell the story of the bankruptcy families to the rest of Congress, then their story is lost. It stops here, and it stops today.

So if you ask for those last two pieces of advice, as you did, one is please don't make this bankruptcy system even worse. Please consider making it better. But secondly, please take these stories into the larger debate about what we are going to do with health care in the United States.

Chairman CONYERS. Do you think reviewing the sub-prime consideration in the bill or the means tests would be good starting places?

Ms. WARREN. Congressman, I think there are so many good starting places in that bill it is almost hard for me to answer. I think those would be fine points of entry, sir.

Chairman CONYERS. Director Rukavina?

Mr. RUKAVINA. Chairman Conyers and distinguished Members of the Committee, I would like to thank you for the opportunity to speak before you today. I am not an expert on personal bankruptcy. I have far too much experience working directly with individuals who have medical debt, however. And I know what happens with those individuals.

That debt is contagious. It is passed on to other family members. That debt is converted to other forms of debt. People take medical debt, medical bills, put it on credit cards. They take out loans. They do take out second mortgages.

As a result of having medical debt, liens are put on accounts that they have on homes. Wages are garnished. All of these are things that are terrifying for someone who is trying to get access to health care.

I don't know that I have much to suggest in terms of the bankruptcy law and what should be done. It doesn't seem, from my anecdotal information and the research I have read, that much has improved for people with medical debt since the reforms.

However, I am wondering if there is some information that can be mined. One of the previous speakers mentioned credit counseling. We worked with a credit counseling service looking at reasons for people seeking those services. And when we did a survey several years ago, the counselors themselves were surprised to learn that two out of every five people seeking their services were there because of a medical incident.

And I am wondering if this Committee can mine the information that exists in the credit counseling services. These are services that is the new requirement under the Bankruptcy Reform Act. And I am wondering if it is possible to look to see whether there is information there that might inform future decisions that this Committee will be making.

Chairman CONYERS. Thank you so much.

Dr. David Himmelstein?

Mr. HIMMELSTEIN. I am no expert in bankruptcy and cannot advise the Committee on the bankruptcy laws at a general level. On medical bankruptcy we are in the process of going into the field for a second round of our study and seeing what the recent changes

have wrought in the population. But we don't yet have those results. So what whereof one does not know, thereof one should not speak. And I will not speak further of that.

But what I will address briefly is a health care system which has cost without benefit at this point so that when we say we weigh the costs and the benefits, the business structure of our health care system is a cost without a benefit. Where we take wonderful colleagues of mine like Jack Rowe, who is a superb geriatrician making $250,000 a year at Harvard and instead we say go to AETNA and there, Dr. Rowe, you can make $250,000 a day each day, including weekends and holidays if you turn from being a doctor to being a businessman.

Chairman CONYERS. How is that done?

Mr. HIMMELSTEIN. Jack Rowe was the CEO of AETNA after leaving Harvard where he was chief of geriatrics. And as CEO of AETNA, his payment amounted to $250,000 each day. That was money drained from our health care system.

We have a debt collection system and a billing system which drains enormous resources from our health care system and which turns doctors into businesspeople. And I guess what I would ask of this Committee and of the Congress is to return us to the calling of our profession and allow us to take care of patients and not worry about the enormous profits to be made off the health care system and not to be burdened by paperwork.

When the honorable gentleman from Ohio spoke of the physicians whom he met with in his district and his surprise at seeing the relative support there. It is not just that they were small-business men who were struggling. We have actually surveyed colleagues on this.

Most doctors are prepared to give up income, give up income if we relieve them of the paperwork burden. More than half of doctors in this country say they would give up 10 percent of their gross income if we would relieve them of the paperwork burden that our insurance system inflicts on them.

So what the Congress can do is stop us from being businesspeople. And, in fact, most of us would be perfectly happy to make a little less if we could just take care of our patients. We make good livings. But let us take care of our patients, and let us not be part of inflicting further suffering on our patients, which all too often we do today.

So I guess the poet laureate of Kentucky said years ago that rats and roaches live under the laws of the jungle and supply and demand and it is the privilege of human beings to live according to the laws of justice and mercy. And that is what most of us went into medicine hoping to be part of. And help us to return to that. Thank you.

Chairman CONYERS. Thank you so much.

Chris Cannon, the last word?

Mr. CANNON. Thank you, Mr. Chairman. I actually have some questions. Do I have enough time to ask?

Chairman CONYERS. Yes, of course.

Mr. CANNON. You know, this is a fascinating hearing. It goes beyond bankruptcy. I appreciate some of the comments that may be helpful as we look at bankruptcy again.

But as we look as a country at what we do with our health care system, it seems to me that you guys, at least a couple of you, are peculiarly postured to help us understand a couple of things that I am thinking, particularly Ms. Smith because you have been through some of these things.

And, Dr. Himmelstein, I think you are the only medical doctor on the panel. Right?

And this is our last panel. So thank you.

And tap me or something if I bore you. But——

Chairman CONYERS. You are never boring. I don't always agree with you, but we certainly listen carefully to each other.

Mr. CANNON. Thank you. And with some facts on the table, I think there are some places we can go.

Chairman CONYERS. Absolutely.

Mr. CANNON. In the first place, though, the world has radically changed about medicine.

I would like, Dr. Himmelstein, for you to respond to a couple of things. In the first place, the current X prize. The last X prize was for Burt Rutan who won the prize by going into sub-orbital space twice. And the X stands for 10 as in $10 million.

The next X prize is for the company that can decode an individual's DNA for $1,000. Are you familiar with that? And we are actually getting close. We are not there. I mean, it is a long way. But we are a lot closer to $1,000 than we were from the amount of money we started at when we did the original decoding of the DNA.

That seems to me to be profound for how we look at the future of health care. Is that not the case, do you think? In other words, the fact that we can get your DNA—suppose we could do it for $1,000 today. You could have your DNA decoded. I could have mine decoded.

If we both have a problem, we treat the problem with the same medicine. You get better. I get worse. We look at our DNA to find out what the difference may be.

Mr. HIMMELSTEIN. Yes, we are a ways from doing that and from the practical implications that one would dream about from that. But at some point that will clearly have a profound impact on our health care system.

Mr. CANNON. But we are down to the point where, you know, if you take the HapMap that was recently completed—and the University of Utah played a big part of that—that, at least a HapMap can be done for less than $30,000, I think, now for an individual. So——

Mr. HIMMELSTEIN. Right. And what it is doing essentially is breeding very important research leads. And we are still quite a ways from being able to take advantage of results from those research leads.

Mr. CANNON. Let us pursue that, what it means to be quite a ways away. And, you know, we now have these computers that have massive multiple processors that do trillions and trillions of transactions a second.

When you combine DNA with lifestyle choices and personal information and start looking at the effects of different protocols, that is a complex system of statistics rather than a double blind study,

doesn't that have a tendency to open up radical new ways to look at results and back from that, into causation?

Mr. HIMMELSTEIN. We hope so. We don't have proof of that, certainly, at this point. And we are, I would suspect, quite a ways from that.

On the other hand, we have enormous untapped known potential for improving health. So we know——

Mr. CANNON. I am going to get to that point as well. But I just want to create kind of—I don't know why you are—it is going to take the time it takes. But what we have today is a relative cheap process of decoding DNA, which allows us to do radically more than we could do 2 years ago.

Mr. HIMMELSTEIN. Absolutely.

Mr. CANNON. And we have computers which are radically more powerful than they were 2 or 3 years ago.

Mr. HIMMELSTEIN. Absolutely. But I would tell you when I was a resident in 1978 I wrote a paper about how computers were going to revolutionize medicine in the next 5 years.

Mr. CANNON. But they did to some degree. Now, the profession didn't adopt them in the ways that I think you were talking about a moment ago that would help us implement——

Mr. HIMMELSTEIN. I would invite you to most clinics around this country—and what was said by the Committees in 1978 about what computers were going to do are still being said by the Committees today. And the timeframe they are predicting is the same 5 years from now.

Mr. CANNON. But it is a dramatically different—it is a different environment, you would grant that, would you not?

Mr. HIMMELSTEIN. Absolutely.

Mr. CANNON. That is important as we look at what our policy is going to be because I personally believe, after having consulted with some of the really brilliant people in America on this issue, that we could increase our understanding of disease and causation 50-fold with the money we are investing right now just based upon changing a few things.

Let me get to what I think is a final point because there is a lot we could talk about here. But are you familiar with—I think you smiled earlier when I mentioned Brent James' name at IHC. Are you familiar with Brent?

Mr. HIMMELSTEIN. Yes.

Mr. CANNON. He is——

Mr. HIMMELSTEIN. We are speaking at a conference together in August.

Mr. CANNON. Interesting. He is one of the more interesting people I have met because he points out that a doctor can only understand seven or eight or nine variables at any given time. And so, you may get radically different instructions from a doctor from morning to night in caring for the same patient with little change in the condition.

And so, he has come up with a system in the case of—well, various systems—but in the case of diabetics, he has taken the average diabetic that is being served and by taking a complex system and tracking complex data, he has been able to reduce the average

blood sugar with the AC1 or whatever you call it, whatever that test is.

Mr. HIMMELSTEIN. A1C.

Mr. CANNON. A1C, right—from nine to under seven. And if you are under seven, you don't have the complications with diseases with feet. And this really gets back to the problem that your husband had, was a botched job or the intuitive nurse that gets you the right kind of treatment. And there is a great deal of intuition which can be helpful or fail in the system.

And what Dr. James is doing is helping create an environment where we use systems to control the variables so that we can enhance the likelihood of having good outcomes. That seems to me to have a terrific potential for how we—and this, I think, was the point you were making about how there are a lot of things we can do now. Do you want to elaborate on those kinds of things we can do today that allow us to improve health care?

Mr. HIMMELSTEIN. Well, I mean, at many levels I think from quality improvement efforts in hospitals and out-patient practices around the country, which Don Berwick and Brent James and others have really been leaders and I am follower of theirs in this field. We could probably save tens of thousands of lives each year by upgrading quality.

I think it is also clear that a more consistent and rational funding system would give us a better base for doing that quality improvement work. And that is why Don Berwick, who was actually knighted by the queen for his work on this and is generally recognized as the quality improvement leader, is one of the supporters of single payer national health insurance in this country.

But clearly, there is that kind of improvement we could make. There is also improvement in prevention that we could clearly make. And I would say this is not just individual choice.

It is not that tens of millions of Americans have decided all of a sudden to start making irrational decisions about eating hamburgers and smoking cigarettes and killing themselves. It is that we have developed a toxic food environment and a toxic non-exercise environment in our country.

And we need to reverse those with some of the things the Chairman talked about at the outset, really changing the water in which we swim to change tens of millions of Americans. It is not just that I like hamburgers that is the problem.

Mr. CANNON. Right.

Mr. HIMMELSTEIN. It is that hamburgers are available cheaply at every street corner and delicious fruits and vegetables are not in many communities and that we have eliminated——

Mr. CANNON. In any community, with all due respect. In this community you can't get—you can get an apple, one of those green ones that don't taste very good down in the cafeteria.

Mr. HIMMELSTEIN. I mean, I think we absolutely know there are many things we can do in our society to improve health and ranging from public health activities to more consistent application of science and system science and delivery of care, and many of them facilitated by national health insurance as well.

Chairman CONYERS. But could I merely interject that—and turn it back to you, Chris Cannon, that we have been joined by Hilda

Solis, the gentlelady from California, who is a supporter of a universal health concept. But more immediately, she is bringing a group of Members of Congress plus people who work in the field to San Diego, California this weekend. And I think it was out of that interest of the distinguished panel of witnesses that she came by. And we are so happy to have her here.

I yield back.

Mr. CANNON. Thank you.

In talking about prevention, we were talking earlier about the difficulty in predicting the timeframe for the benefits from massive computers and DNA. But if we just made more information available to individuals in a way that they could rely on it—is that not one way that we could actually enhance people's ability to do prevention on their own?

Mr. HIMMELSTEIN. It is an attractive hypothesis as yet unproven. I mean, we just had a paper published this past week looking at the quality of care in practices using electronic health records versus those not using electronic health records. And we all thought that that was going to show a markedly positive benefit and, in fact, showed no benefit whatsoever. So I would say it is as yet an unproven but attractive hypothesis.

Mr. CANNON. My point doesn't go to electronic health records so much as an individual having access to information to understand what is good for him so he could make better choices.

Mr. HIMMELSTEIN. Right. We would certainly like to think that is true.

Mr. CANNON. And to the degree that he can have personalized understanding of what would help him or her, you would expect——

Mr. HIMMELSTEIN. But if you can't buy fruits and vegetables, you still can't eat them.

Mr. CANNON. That is exactly right. But if people understand what that will do to their health, it will increase. The market will respond to that.

Mr. HIMMELSTEIN. I hope so.

Mr. CANNON. I am not sure the congressional market will respond to that, or at least not at the cutting edge.

But let me just touch on one other topic, if the Chair will indulge me. Today the FDA bases its review of drugs on toxicity and efficacy. You have to understand toxicity is a very complex subject. And I don't want to move into that very much. But efficacy is how it works. And couldn't the market decide that?

In other words, one of the things that I think should free up doctors—and I have talked to many about this—is if they had the—and doctors do have the ability to prescribe any drug that they want for any problem. Their problem is that if somebody gets cured on what is not a standard protocol and others come to him, he could end up being called a quack. Or on the other hand, you could end up with a prosecution like happened with Merck here 6 or 8 months ago where they pled guilty to promoting an off-label use.

Couldn't we do something with efficacy in the FDA? Say a doctor comes up with a protocol and says to the FDA, "I would like to do this. I would like other people to do it as well. Would you call it not dangerous so we could proceed with that protocol?"

And then doctors would be encouraged to do different protocols. They preempt being called quacks, on the one hand. On the other hand, if things worked and doctors now used their genius to figure out what might work, or drug companies or others, you end up with information about drugs that is not available currently, given the protocol or the process that we use at the FDA. Does that make sense to you, Dr. Himmelstein?

Mr. HIMMELSTEIN. Well, if we add information of high quality, then it makes sense. I fear that much of the information that we are actually adding in the drug review process at this point is of such low quality as to be virtually useless, other than its propaganda for the drugs.

Mr. CANNON. Right. Exactly, which, by the way—I mean, the difficulty with what is useful information really then devolves to the physician who has got the training to make decisions and to advise and counsel his patients, which is something I would dearly love to see. That is physicians driven by an interest in the health of their patients instead of seeing their patients as money machines that they pull the lever on and pay.

Mr. HIMMELSTEIN. Well, and we should recognize that at this point the vast majority of drug education in this country of physicians is carried out by the drug companies.

Mr. CANNON. Right.

Mr. HIMMELSTEIN. The drug companies' budget for mis-educating physicians is larger than the teaching budgets of all the medical schools in the United States combined.

Mr. CANNON. Yes.

There are many, many more things to talk about, Mr. Chairman. I appreciate your indulgence. Let me say this is an issue of enormous importance to me. As I said earlier, virtually every family in America has had a tragedy. We certainly have had tragedies around my family. That is a personal issue. And I would love to see an environment where we shift from—I think, Dr. Himmelstein, you talked about this—toxic environment of drugs.

Perhaps that was you, Mr. Chairman—this toxic environment where all the incentives are distorted and the result is these kind of horrible tragedies that compound within a family, destroy a family.

Well, you haven't been destroyed, with all due respect, Ms. Smith. I appreciate the fact that you are here. But much of your life, much of what you anticipated for your life to become—because of a series of issues, some of which may not have been controlled. But with all due respect, I am more optimistic than Dr. Himmelstein. And I have been around some of the downside of this for a very long time.

I believe that if we are thoughtful in Congress we can create an environment where people can make healthier choices, where the market will respond to those choices by providing better services and where doctors can get away from a system—I will just tell you that in many cases, in my experience, you go to a doctor. He looks at you like a lever, a monkey in a cage, has the lever. He pulls the lever, a banana comes out.

You walk into the doctor's office, the monkey pulls the lever, and he gets the payment. That is toxic. It is only a small portion of the

whole system, but it is destructive to the doctor as much so as it is to the patients.

So the most educated people in America, the people that spent the most time as a group on education, end up being monkeys pulling levers instead of people who help us be healthier. I think there is something profoundly wrong. The way we have done this historically or the way we have let the system evolve is profoundly wrong. And bankruptcy is a minor problem in this much larger problem.

And so, I appreciate, Mr. Chairman, you having this hearing and going beyond, I think, the simple bankruptcy issues to those issues that are behind that. And with that, I yield back the balance of my time and thank the panel for your being here.

Chairman CONYERS. Thank you so much.

We usually give 5 days for Members to get any questions to you and to get them back to us. And then we have 5 days for us to submit any additional materials into the record that we want.

This has been an extraordinarily long but meaningful, might even become historic because there is so much to study and examine. The witnesses have been tremendous.

And we are delighted that so many of our Subcommittee Members and other Members were here to share this afternoon with us.

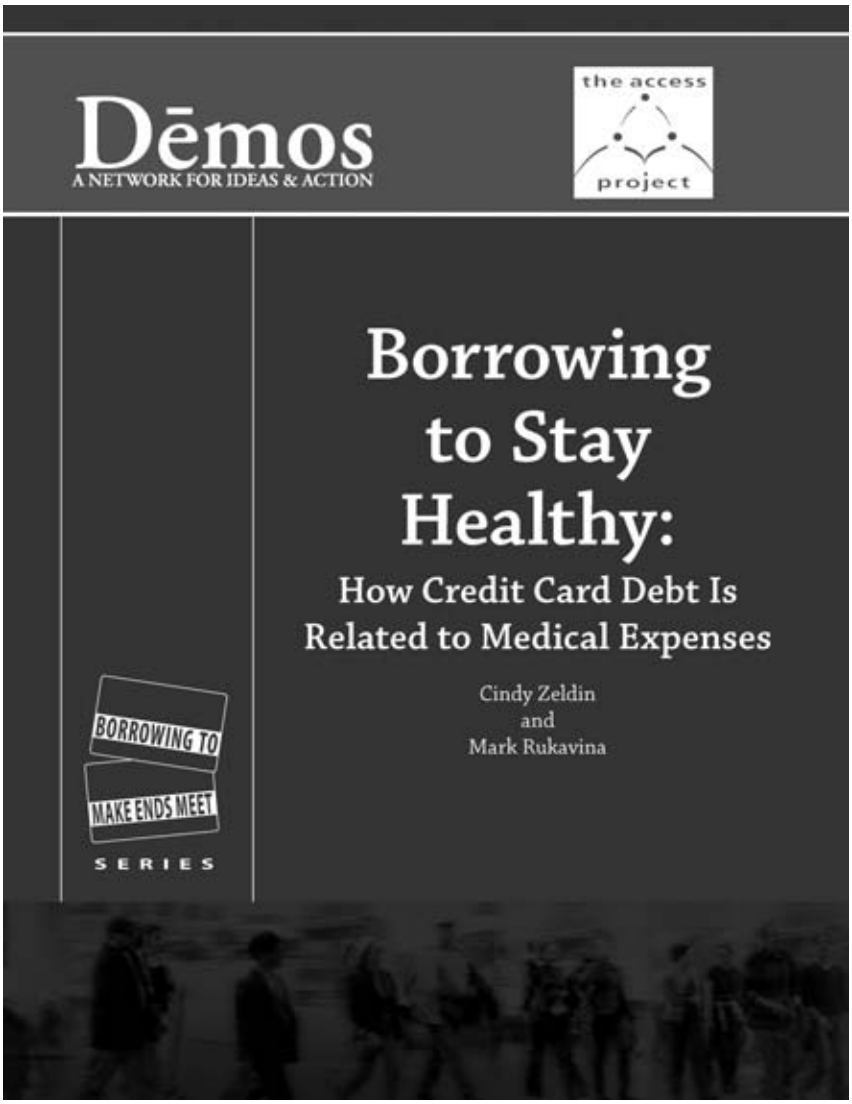
With that, the Subcommittee on Commercial and Administrative Law hearing is concluded. Thank you so much.

[Whereupon, at 4:44 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Additional Information Submitted by Mark Rukavina, Director, The Access Project, Boston, MA



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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.

Borrowing to Stay Healthy:

How Credit Card Debt Is Related to Medical Expenses

Cindy Zeldin and Mark Rukavina

Contents

Key Findings 1

Background 2

Methodology 3
Findings on Medical Expenses and Credit Card Debt 4
Health Insurance Status 5
Age 6
Households with Children 7
Race/Ethnicity 7
Income 7

Consequences of Medical Debt: Credit Card Balances, Worse Health Care, Depleted Assets 8

Areas for Future Study 9

Policy Recommendations 10
Differentiate Medical Debt from Consumer Debt 10
Limit the Entry of Medical Providers into Financial Services 11
Increase Oversight of Lines of Credit Attached to Health Savings Account Products 11
Ensure Adequacy of Insurance Coverage 11
Improve screening for eligibility in public or private financial assistance programs 11
Enact a Borrower's Security Act 12

Notes 13

Appendix: Case Studies 18

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 households 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 ($10,978).
- Average credit card debt was higher for households with children ($12,840) than for those without children ($10,569).
- The medically indebted are more likely to be called by bill collectors than those without such medical expenses (52 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. The cost of health insurance continues to outpace overall inflation and wage growth, placing added pressure on already stretched family budgets. Over the past six years, health insurance premiums have increased by 73.8 percent, while median income has grown by only 11.6 percent. A family health insurance policy is now equivalent to 18 percent of median family income, up from 8 percent in 1987.

Most Americans with health insurance have coverage through their own or a family member's workplace. 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. Some are eliminating coverage altogether, and the share of working-age adults covered by employer-sponsored health insurance is in decline. Public programs like Medicaid are not growing to meet the gap, individual health insurance policies can be prohibitively expensive, and the number of uninsured Americans continues to creep upward. In 2005, nearly 47 million Americans were uninsured.

Uninsured Americans are particularly vulnerable to medical bill problems and to medical debt, 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. Numerous studies have found that large numbers of both insured and uninsured Americans have difficulty paying medical bills and are even falling into debt.

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; 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; that roughly half of all personal

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

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. In general, the trend for health insurance policies has included higher deductibles and co-payments for hospitalizations, office visits, and prescription drugs, which, in turn, increases the financial burden for people who get sick. Medical debt can also be tied to less-comprehensive insurance. 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

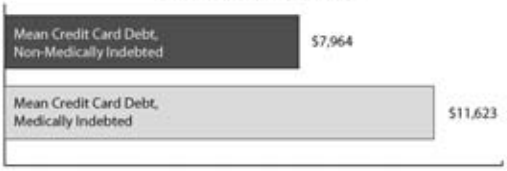
	Mean	Median
All	$11,623	$7,000
By Age		
18-34	$13,303	$6,150
35-49	$10,500	$8,000
50-64	$12,515	$7,000
65+	$6,823	$4,000
By Income Level		
Less than $35,000	$8,774	$5,000
Between $35,000 - $50,000	$12,429	$6,600
Greater than $50,000	$13,583	$7,800
By Race/Ethnicity		
Non-Hispanic Caucasian	$11,971	$7,800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

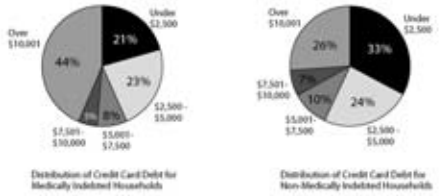
Table 1, which is not surprising since health expenditures tend to be highly concentrated. Average debt is important, however, because it reveals how financially devastating medical debt can be for those who have the misfortune of becoming seriously ill.

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.

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, 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.

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. 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.

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. 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. Medical bill problems and medical debt are more frequently reported by people in higher deductible plans. As these types of plans proliferate, out-of-pocket expenses could grow even more, thus increasing the potential for medical debt.

As deductibles and co-payments increase, hospitals are finding more patients unable to pay their medical bills. 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). 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. 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 $19.6 billion in health care services to Visa cards. 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.

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. 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. 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. 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. 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. 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.

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.

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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.

10. Kaiser Family Foundation/eHealthInsurance, "Update on Individual Health Insurance," Revised August 2004. Also, it is worth noting that, depending on the state, individual health insurance policies can be priced differently for people of different ages and health statuses. Data on the cost of individual health insurance is usually drawn from actual insurance policies and not their "sticker price." If someone chooses not to purchase individual health insurance after receiving a high price quote, for example, the price they were quoted

11. U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," August 2006.

12. Michele M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills: Results from a National Survey," The Commonwealth Fund, August 2005

13. ABC News, Kaiser Family Foundation, and USA Today, "Health Care in America 2006 Survey, October 2006.

14. See The Access Project, "The Consequences of Medical Debt: Evidence from Three Communities," February 2008; David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhander, "Illness and Injury as Contributors to Bankruptcy," Health Affairs Web Exclusive, February 2, 2005; Jessica H. May and Peter J. Cunningham, "Tough Trade-Offs: Medical Bills, Family Finances and Access to Care," Center for Studying Health System Change, Issue Brief No. 85, June 2004; and Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgrem, "Seeing Red: Americans Driven into Debt by Medical Bills: Results from a National Survey," The Commonwealth Fund, August 2005.

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24. Steven R. Machlin and Marc W. Zodet, "Out of Pocket Health Expenses by Age and Insurance Coverage, United States, 2003." Statistical Brief #126. May 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/papers/st126/stat126.pdf

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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 45 years old. David's diabetes and a number of on-going minor health needs necessitate frequent trips to doctors and specialists. As a school psychologist, David 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 sometimes takes up 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 2005 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 2005, 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 healthcare 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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By Bob Seifert And Mark Rukavina

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Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security (January 2006)
By Carol Pryor and Jeffrey Prottas

Using data from a survey of over 1,000 people at four Community Health Centers across Kansas, this report reveals that medical debt is a growing problem throughout the state, and belies the myth that health insurance always provides adequate financial protection from debt.

Home Sick: How Medical Debt Undermines Housing Security (November 2005)
By Robert Seifert
Based on a survey of 1,700 low- and moderate-income taxpayers in seven cities, this report reveals that medical debt can contribute to housing problems and other financial woes for both the insured and uninsured.

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PERSPECTIVE

Bankruptcy Is The Tip Of A Medical-Debt Iceberg

Tracking the number of uninsured Americans is only part of the story: How many insured Americans incur medical debt that deters them from seeking care?

by Robert W. Seifert and Mark Rukavina

ABSTRACT: Medical bankruptcy, whatever its actual frequency, is an extreme example of a much broader phenomenon. Medical debt is surprisingly common, affecting about twenty-nine million nonelderly adult Americans, with and without health insurance. The presence of medical debt, even for the insured, appears to create health care access barriers akin to those faced by the uninsured. Policymakers, researchers, and medical providers should consider medical debt a risk factor for reduced health access and poorer health status. Simply reducing the number of uninsured Americans would be a hollow policy victory if the problems arising from medical debt persist. [*Health Affairs* 25 (2006): w89–w92 (published online 28 February 2006; 10.1377/hlthaff.25.w89)]

DAVID DRANOVE AND Michael Millenson agree with David Himmelstein and his colleagues on one essential point: that illness and bankruptcy are a "genuine human tragedy."[1] They differ on the degree to which the financial burden of illness contributes to bankruptcy and, therefore, on policy remedies to alleviate the problem. Their debate also illuminates an intersection between personal finances and the health care system that has much broader implications. Our contention is that pervasive medical debt hinders access to health care for millions of Americans and should be considered a risk factor, akin to lacking health insurance, when one is designing policies to improve access.

Bankruptcy is the extreme example of financial overextension, as medical bankruptcy is at the extreme end of the spectrum of medical debt. Whatever the level of medical bankruptcy, the actual problem is much greater because medical debt, as is becoming increasingly apparent, is pervasive and damaging not only to personal finances but to health care access as well.

While health care is an important part of the U.S. economy and a vital service, access to care is by no means universal. For many Americans, health insurance coverage is elusive, making it difficult to access health care services. Between 2000 and 2004, the number of Americans without health insurance increased by six million, reaching 45.8 million in 2004.[2]

Given health care cost trends, it is likely that the ranks of the uninsured will continue to grow. Health insurance premiums increased 73 percent between 2000 and 2005, while

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workers' wages increased 15 percent and the general rate of inflation was approximately 14 percent.[3] For Americans with health insurance, the vast majority have employment-based coverage, although the proportion of workers receiving coverage through their employment is falling. Approximately 60 percent of Americans received coverage through the workplace in 2004, a decrease from 64 percent in 2000.[4]

The average worker with employment-based coverage paid premiums of $2,713 for family coverage in 2005, an increase of $1,094 since 2000. As premiums are rising, employees face additional cost burdens from deductibles and copayments for hospitalization, office visits, and prescription drugs.[5]

> **"The care-seeking behavior of privately insured adults with medical debt is like that of uninsured people."**

Health insurance premiums and out-of-pocket costs capture only part of the true cost of health care for many U.S. families, however. The full financial burden of health care must also take into account medical debt or money owed for medical products or services.

■ **Medical debt adds to the financial burden of premiums and cost sharing.** Medical debt is surprisingly common. A recent national survey found that one out of six nonelderly adults—about twenty-nine million people—had recent or accrued medical debt.[6] The risk of medical debt is greater for people without health insurance, but even those who are insured are not immune; 15 percent of those who had insurance for all of the past twelve months reported having medical debt, and 70 percent of all those with debt said that they were insured at the time the debt was incurred.[7] Many of these people could be characterized as "underinsured"—nominally covered but inadequately protected.[8]

Another national survey found more than fifty-eight million U.S. adults at high risk of incurring medical bills they might not be able to afford.[9] This figure included more than forty million adults who were uninsured for all or part of the previous year and 17.6 million adults with private insurance reporting substantial problems paying their medical bills.

The Access Project has done community-based research around the country; its findings are similar to these national survey data. A 2000 study conducted in twenty-four communities found that almost half of the nearly 7,000 uninsured respondents had unpaid bills or were in debt to a particular safety-net facility in their community.[10] The Access Project's 2005 study of low-income taxpayers in seven communities again found that 46 percent had medical debt.[11]

The problem of medical debt also plagues middle-income Americans. Fully half of those with private insurance and medical debt had household incomes of more than $40,000; among this group, one-third were college graduates or had postgraduate educations.[12]

■ **Medical debt is a barrier to access.** Analyses of access to care often compare insured and uninsured groups; however, it appears that the care-seeking behavior of privately insured adults with medical debt is much more like that of uninsured people. On a number of standard access measures, respondents to a national survey reported that medical debt, even among insured people with a "medical home," presents nearly as high a barrier to access as having no insurance at all.[13]

People with medical debt—both uninsured and those with private insurance—are much less likely than those without debt to fill a prescription, see a specialist when needed, or visit a doctor or clinic for a medical problem, and they are more likely to skip a needed test, treatment, or follow-up.[14] In a recent study, just over one-quarter of those with medical debt said that they changed primary care doctors because of the money they owed for care.[15] Among uninsured people who owed money to a safety-net provider, one-quarter said that they would be deterred from seeking care at that facility in the future.[16]

Many of the reasons for forgoing needed care because of debt are self-imposed: pride,

embarrassment, or simply the reluctance to add to one's debt burden. Other reasons, though, are imposed from outside. Providers, for example, might require a deposit or full payment in advance from patients who owe for past services. Some have policies to refuse services outright—sometimes to all family members—until past-due bills are paid.[17] And many hospitals use aggressive, punitive debt collection practices, including outside collection agencies and lawsuits, that might serve to deter patients from seeking further care if they are unable to pay promptly.[18]

Financial consequences of medical debt. The consequences of medical debt ripple far beyond health care access. Medical debt undermines families' economic security in various ways. Often, families exhaust savings trying to pay off medical debt. One national survey found that 44 percent of those with medical debt used all or most of their savings to pay outstanding medical bills. Families also trade medical debt off for other types of debt. In the same survey, one in five medical debtors took on large credit card debt or a loan against their home to pay medical bills.[19] These debts can also be contagious. About two in five people with medical debt in an Access Project study in Kansas borrowed money from friends or family to pay their medical bills.[20]

People with medical debt are often subject to legal judgments, wage garnishment, attachment of assets including bank accounts, or liens on their homes, which can lead to foreclosure.[21] It is typical for people with medical debt to be contacted by collection agencies, experience employment problems, and have difficulties accessing loans or credit.[22] It is clear that even before it pushes some families to the crisis of bankruptcy, medical debt destabilizes the finances of a sizable number of Americans and thus creates strong incentives not to seek needed medical care.

"It is clear that even before it pushes some families to the crisis of bankruptcy, medical debt destabilizes the finances of a sizable number of Americans."

Implications and recommendations. The annual estimate of uninsured Americans has long been seen as a reliable proxy for the state of health care access. This simple measure would allow us to claim victory when (and if) new policies succeed in reducing the number of uninsured Americans. That victory will be a meaningless one, however, if we disregard the access barriers faced by the underinsured and those with medical debt.

Recent research findings cry out for new measures to assess how well our country is addressing the health care access issue. It is now documented that medical debt resulting from being uninsured or having inadequate insurance reduces access to care and undermines the financial security of American families. Thus, this debt is, in itself, a risk factor for reduced access and poorer health status.

Policymakers, researchers, and medical providers should all be encouraged to focus attention on this risk factor. Financial protection must be a tenet of health insurance. Insurance products that require patients to pay more and more of the cost of their care through higher deductibles and copayments must take into account the income of patients in setting cost-sharing limits. Requiring additional costs to be borne by the patient will likely have a detrimental effect on access, particularly for those with chronic illnesses, although low-wage workers and even middle-income families may be at risk as well.

To truly improve health care access for Americans, it is time to expand our policy vocabulary beyond insurance coverage and begin to examine the adequacy of that coverage in ensuring health access and improving health status and financial security.

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HOME SICK
How Medical Debt Undermines Housing Security
By Robert W. Seifert
The Access Project
November 2005

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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Contents

Executive Summary	1
I. Introduction	5
II. What We Knew: Past Research on Medical Debt	7
III. Methods	11
IV. Survey Findings	12
V. Discussion	18
VI. Policy Recommendations	20
VII. Conclusion	23
Appendices	24
Endnotes	27
Acknowledgements	29

Executive Summary

Access to health care depends to a great degree on the ability to pay for it, either with insurance or out of one's own pocket. Even when uninsured people or those with inadequate insurance are able to get care, they usually receive a bill for it, which can subsequently wreak havoc in the form of excessive debt, damaged credit and other financial misfortune. This report is about how medical debt affects one important aspect of people's lives—their housing situation.

We surveyed nearly 1,700 low and moderate income people in seven locations[1] who were filing income tax returns in Volunteer Income Tax Assistance (VITA) sites. Many were eligible to claim the federal Earned Income Tax Credit. Nearly half of these respondents reported having medical debt.

Key Findings

The survey shows important connections between medical debt and significant financial hardships:

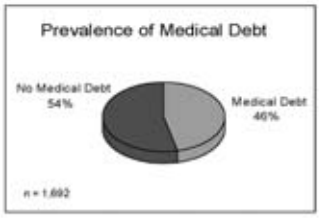
Housing problems were common

More than one-quarter of respondents with debt said housing problems resulted from the debt. Problems included:

- the inability to qualify for a mortgage
- the inability to make rent or mortgage payments
- being turned down from renting a home
- being forced to move to less expensive housing.

In addition, some people said they have been evicted or were now homeless because of medical debt.

These findings establish medical debt as a barrier to important elements of economic advancement, namely asset development and housing security. Respondents in all racial and ethnic categories, as well as all income categories captured in the survey, were substantially affected.



Bad credit was a frequent result of medical debt

Our survey found that most people did not know whether their medical debt was on their credit reports, but of those who did know, three in five said it had damaged their credit. Damaged credit affects people's ability to secure a mortgage or to rent an apartment. It may also be a barrier to employment and auto or home insurance, and has other repercussions as well. The effects of damaged credit linger: a delinquent account can remain on a credit report for seven years.

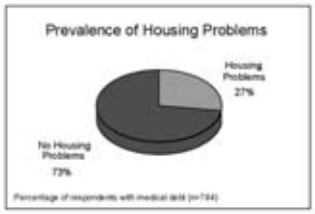
Respondents whose medical debts appeared on their credit reports were twice as likely to experience housing problems as those whose credit reports did not include medical debt. Respondents with medical debt who are not yet aware of their credit status are likely to find their credit hurt—an unwelcome surprise when trying to buy a home or access other credit.

One out of six respondents with medical debts less than $500 said that the debt had harmed their credit

Unlike many other types of debt, medical debt usually can only harm a credit rating, not help it. When medical providers and their collection agents report debt to credit bureaus, they typically only do so when payments have *not* been made. This negative-only treatment of medical debt is all the more inequitable because it is one of the few types of debt that are involuntarily acquired. Thus this "accidental debt," even if relatively small, essentially acts as a sickness tax—on top of the bills themselves and possible lost employment income—by damaging credit.

Relatively small debts had far-reaching effects

One out of six respondents with medical debts less than $500 said that the debt had harmed their credit. Twelve percent of respondents with this level of debt reported having housing problems.



The financial pressure that these housing and economic disadvantages create seems out of proportion to the modest level of debt that brings them on. Adding to this pressure is the additional finding that housing problems become more likely as medical debt lingers.

Health insurance did not provide thorough protection

The respondents with medical debt in our survey more often than not had health insurance at the time the debt was incurred. One out of five respondents who had health insurance said their medical debt had led to housing problems. Though the lack of health insurance put people at great risk for medical debt and its consequences, those with insurance were by no means immune. People with insurance, particularly those who can be considered "underinsured," are responsible for increasing shares of the health care costs, through deductibles and copayments, or through outright payment for uncovered services. That health insurance seems not to have served its fundamental purpose for many survey respondents warrants further attention in the public policy arena.

Past Research

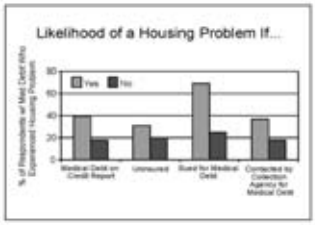
This large scale survey of low and moderate income, working age adults verifies a central finding of a number of recent studies by the Commonwealth Fund, the Kaiser Family Foundation, The Access Project and others: medical debt is a common phenomenon. A variety of national surveys found significant levels of medical debt, especially among low income people, those under 65 years old, and those without health insurance (though a majority of adults with medical debt problems were insured at the time the debt was incurred). Effects of the debts included limited access to health care, inability to accumulate savings and purchase basic necessities, collection actions such as wage garnishment and home liens, personal bankruptcy and, in the extreme, incarceration.

Community-based research that The Access Project and others have done had comparable findings. In exploring the extent and consequences of medical debt, The Access Project and its local partners heard recurring anecdotes about medical debt acting as a barrier to home ownership. The desire to investigate this question more thoroughly gave rise to this study.

Areas for Policy Recommendations

Medical Providers

Medical providers can contribute to solving the problem by reducing the amount of medical debt they create and changing practices, the effects of which cascade into additional financial difficulties. Actions might include instituting reasonable billing and collection practices and adequately screening patients for eligibility in public insurance programs. In addition, other types of providers (such as doctors' offices, medical labs, ambulance services) have not been held to account on this issue to the same extent as hospitals. Further scrutiny and standards regarding providers' relationships with collection agents, lenders, and credit bureaus would bring focus to additional policy solutions.



Insurers

That people with health insurance are affected by medical debt and its consequences almost to the same degree as those without, calls into question the adequacy of some insurance in fulfilling its primary purpose: protecting the insured from financial catastrophe. Standards for adequate coverage, including cost sharing obligations that are proportionate to family incomes, might be explored, as well as programs to provide benefits to the communities in which insurers operate.

Further research is also needed to understand the relative influences of various shortcomings in health insurance—excessively high deductibles, breaks in coverage, uncovered services—on medical debt and resulting problems. Knowledge of this sort will help policy makers determine how standards for adequate coverage could be set, so that the purpose of health insurance as financial protection might be restored and maintained.

Lenders and Affiliated Organizations

Lenders might reasonably be asked to develop explicit policies for segregating medical debts in considering an applicant's eligibility for credit, but this presumes that medical debt is readily identifiable as such on a credit report. Given the atypical nature of medical debt and the commonly expressed policy to treat it differently, one might question the need for health care providers to report these debts to credit bureaus at all. Lenders, creditors, credit bureaus and regulators should consider ways to prevent medical debt from ever tarnishing a credit record, including rules to prohibit medical providers and their agents from reporting medical debt to credit agencies.

If there is a more vulnerable circumstance for a person to be in than being ill, it is probably to be ill and in debt

Conclusion

If there is a more vulnerable circumstance for a person to be in than being ill, it is probably to be ill and in debt. This report has shown that such vulnerability is not rare among our survey respondents. To compound this, medical debt often results in housing and credit problems, which in turn may bring about further crippling financial difficulties.

Repairing the health care system—controlling costs, improving quality, ensuring access and eliminating disparities—is a challenge of national scope that has, to date, been maddeningly elusive. Smaller victories are achievable, however. One place to look is eliminating the financial penalty imposed on people for getting sick. Remedies—on the part of policy makers, medical providers, insurers and lenders—are at hand. All that is needed is action.

I. Introduction

"Anyone can get health care if they really need it." This is a typical response to the reality of growing numbers of uninsured and inadequately insured people in the United States.[2] Americans believe that a safety net of emergency rooms, free clinics and other facilities are available to provide care to those without the means to pay for it, so that no one need go entirely without health care services.

This belief is false. A large body of evidence has established that access to health care depends to a great degree on the ability to pay for it, either with insurance or out of one's own pocket. This research has brought to light another consequence of this situation: even when people are able to get care, they usually receive a bill for it, which can wreak subsequent havoc on their finances and access to health care. Those bills, and their effects on people's lives, are the subjects of this report.

The Access Project has been exploring the issue of medical debt for several years, since the issue emerged through some of its community-based research as a significant but relatively unremarked barrier to health care.[3] Further examination exposed significant financial consequences of the debt as well.[4] At the same time, community organizations across the country are engaged in these issues at the local and regional levels through their health care advocacy, economic improvement and community organizing activities. The Access Project has joined forces with a number of these groups—ACORN chapters in Bridgeport, CT; Providence, RI; Atlanta, GA and Phoenix, AZ; The United Way of Palm Beach County, FL; ISED Ventures in Des Moines, IA; the Community Action Project of Tulsa, OK; and the Center for Health Law Studies at the St. Louis University School of Law, MO—to produce this report, which is based on surveys conducted in eight communities.

Even relatively small amounts of debt—$500 or less—created housing problems for substantial numbers of people

Findings from the survey corroborate earlier research on the scope and effects of medical debt.

Nearly half of the 1,692 survey respondents said they had medical debt, and debt was reported to a roughly equivalent extent among all ethnic categories and all income ranges captured in the survey. The surveys also reveal a previously unexplored consequence of medical debt—that it affects low-income families' efforts to own, rent, or maintain their homes.

Our key findings indicate:

- More than a quarter of respondents with medical debt said that the debt resulted in housing problems such as the inability to qualify for a mortgage, to make mortgage or rent payments, or to secure or maintain a home.
- Respondents whose medical debts appeared on their credit reports were twice as likely to experience housing problems as those whose credit reports did not include medical debts.
- Even relatively small amounts of debt—$500 or less—created housing problems for substantial numbers of people.
- Having health insurance did not sufficiently protect many families from either medical debt or the resulting credit and housing problems.
- Medical debt is "accidental debt" that creates a cascade of consequences that ultimately limit the ability of families with moderate incomes to have a secure place to live.

The first section of the report describes past research on medical debt and its consequences. Succeeding sections describe the survey, the survey findings, implications of those findings, and suggested areas for policy changes that could mitigate housing problems related to medical debt.

PERSONAL ACCOUNT

The price of bad luck: chronic illness leads to job loss, debt, eviction

Laura is a thirty-three year old woman with diabetes and a single mother of two children, ages five and thirteen. In 1996, while living in Colorado, Laura had to be hospitalized due to a diabetes-related health crisis. She was unable to work at this time and subsequently lost her job. Crushed by ongoing health care expenses and a backload of debt, most of which was directly or indirectly related to her diabetes care, she filed for bankruptcy later that year. Laura went back to work in December 2001, but in 2003 she became very sick once again, fell behind in her bill payments, and accrued thousands of dollars in debt. Unable to keep up with her rent, Laura and her two children were evicted from their apartment in November 2003.

Laura and her children moved to Iowa in 2004 to be nearer to family. She found a new job that provides health insurance, and her children received health coverage through Iowa's state health insurance program, hawk-i. Despite health coverage and earnings of $38,000 per year, the family's housing situation is still unstable. Laura's efforts to pay down $20,000 of debt—$5,000 of which is owed directly for medical expenses—her ongoing health issues, and the costs of child care make paying the $700 per month rent for her affordable housing unit a constant challenge.

II. What We Knew: Past Research on Medical Debt

Medical debt is money owed for medical services or products, such as hospital or physician's care, prescription drugs and ambulance services. It may be money owed directly to the provider of the service, to an agent of the provider, or to another source (such as a credit card or other lender) that may have been used to pay a bill. The debt itself may represent an entire bill or just the portion for which an individual is responsible, such as a copayment or deductible for a service that is covered by insurance. What is common about medical debt is that it is usually involuntarily acquired in pursuit of a service on which a person's well being (and sometimes life) depends, it is usually not planned for, and it is widespread across the population of the United States.

Although uninsured people are the most obvious victims of medical debt, people with health insurance are also at risk

This section of the report sets the context for the new information, particularly concerning housing consequences of medical debt, which we have discovered from our survey.

Prevalence of Medical Debt

Numerous studies have confirmed that a large portion of the population of the United State experiences medical debt. These studies looked at the issue both nationally and locally, and the findings are consistent. The Commonwealth Fund's 2003 Biennial Health Insurance Survey reported that, nationally, about a third (32%) of adults under age 65 had a medical bill problem (unable to pay a bill, contacted by a collection agency about a medical bill, or had to change way of life significantly to pay medical bills) in the past 12 months, and that one in six (16%) had recent or accrued medical debt. Overall, two in five (41%) non-elderly adults had recent medical bill problems or accrued medical debt.

The number grows to three in five (60%) for people who were uninsured at any time during the past year.[3] Another recent survey found that one American in five (21%) had a medical bill *currently* overdue.[6] Other national surveys, while not as detailed on the matter of medical debt, found similar numbers of people reporting difficulty paying medical bills.[7]

At the community level, Access Project research has found a comparable level of medical debt. In a survey of uninsured people in 24 communities, 60 percent of respondents said they needed help paying their medical bills, and nearly half (46%) reported having unpaid bills or being in debt to the facility where they received care.[8] Another study found that nearly 40 percent of households seeking credit counseling services at an agency in Florida reported that a medical event contributed to their debt problems.[9]

Characteristics of People with Medical Debt

The widespread incidence of medical debt makes it unsurprising that, while more vulnerable groups are more likely to experience medical debt, all economic and demographic groups are affected. For example, while nearly half (44%) of adults with incomes up to twice the federal poverty level[10] had medical bill or debt problems, almost a third (29%) of adults with higher incomes also reported such problems. About half (52%) of African Americans and a third (34%) of Latinos had debt problems, but so did nearly a third (28%) of Whites. More than two in five (43%) adults in poorer health had bill and debt problems, but almost a quarter (23%) of the healthiest people did as well. And as mentioned earlier, three-fifths of people who had been without health insurance at any time in the past year had medical bill and debt problems, but a substantial percentage of people who were continuously insured (35%) did too.[11]

Although uninsured people are the most obvious victims of medical debt, people with health insurance are also at risk. The Commonwealth Fund study found that a majority (62%) of non-elderly adults with medical bill or debt problems were insured at the time the bill was incurred.[12] That finding calls attention to the growing problem of health insurance that does not fulfill its central purpose: to shelter the insured person from excessive financial risk.

The increasing prominence of health plans that require greater contributions from individuals through higher deductibles and copayments means that more insured people—particularly those at the lower end of the income spectrum—will face financial burdens that do not differ greatly from those facing the uninsured.

A recent study conservatively estimated that there were about 16 million "underinsured" adults in 2003, in addition to the 45 million uninsured. The access, care, and financial experiences of the underinsured were more similar to those of the uninsured than to those with adequate insurance coverage.[13] The inadequacy of insurance coverage is another theme of this study, as will be discussed later in this report.

Effects of Medical Debt

People with medical debt experience effects in terms of both their access to health care and their financial well-being. Nationally, people with medical debt are much more likely than those without to skip a medical treatment or follow-up; and less likely to fill a prescription, see a specialist when needed, or see a doctor when having a medical problem.[14] Three out of five (60%) people whose medical debt contributed to their need to file bankruptcy went without a needed doctor or dentist visit, and half failed to fill a prescription.[15]

Past community research that The Access Project has done with local partners supports these findings. In a survey of uninsured people in 24 communities, nearly one-quarter of people with unpaid bills said the debts would deter them from seeking care at the same facility in the future.[16] In a study of people with medical debt in two communities in Massachusetts, about three-quarters (73%) of respondents who delayed getting care because of debt said it was because they were uncomfortable about the bills, 30 percent said they were asked to pay up front, and 14 percent said they were denied care altogether.[17]

The gamut of financial effects of medical debt runs from nuisance to nightmare. It is typical for a person owing money for medical bills to hear from a collection agency; 21 percent of *all* non-elderly adults in the Commonwealth Fund survey had been contacted by collection agents about medical bills in the past year.[18] Some debt counselors consider medical providers to be among the most aggressive collectors.[19] Medical debt also inhibits people's ability to accumulate savings and to purchase basic necessities (food, heat, rent, telephone service).[20] Moreover, the consequences of medical debt sometimes extend even further. People who owe medical bills often find themselves in court and subsequently subject to legal judgments that might include wage garnishment and liens on their homes, sometimes leading to foreclosure.[21] In some cases, failure to comply with court ordered repayment plans have actually landed medical debtors in jail.[22] And medical expenses or lost income due to illness or injury are factors in about half of all personal bankruptcies, about two million people per year.[23]

What's Next: Motivation for This Study

In exploring the extent and consequences of medical debt with its local partners around the country, Access Project staff have frequently heard about these consequences of medical debt. Another consequence was also commonly related: that medical debt was a barrier to home ownership because it prevented people from qualifying for mortgages. If this is, in fact, a common phenomenon, and if medical debt contributes to other housing difficulties as well, it presents a serious challenge both to people who work hard to provide for their families and improve their economic standing—home ownership is a major engine of wealth accumulation for middle class families—and to policy makers who want to strengthen communities by promoting such behavior. The remainder of this report explores how medical debt influences families' housing and overall economic stability.

PERSONAL ACCOUNT

Medical bills build barrier to home-buying

Cynthia and Ronnie are a married couple with four children living in Palm Beach County, Florida. Cynthia has worked for the Pahokee Housing Authority for 8 years and Ronnie has worked at the City of Belle Glade's sanitation department for a year and a half. Together, their family income is just under $43,000 per year. Cynthia and Ronnie wanted to become homeowners, so they accessed their credit report through a Credit Counseling Services office. They were surprised to learn that they had accumulated over $3,000 of medical debt during the past five years despite having had insurance coverage. Cynthia's debt stems from co-payments for the hospital care she received when her child was born, and Ronnie's comes from the costs of surgery that he underwent a few years ago while unemployed and covered by Medicaid. In both cases, they believed these costs would be covered by their respective insurance programs. Paying down their medical debt—as well as a small amount of other debt which they could probably complete in a few months' time—will be difficult for their family, even with two working adults. Cynthia and Ronnie's dream of buying a home will have to wait until their credit is clear enough to secure a loan.

III. Methods

The surveys were conducted in eight cities: Atlanta, GA; Des Moines, IA; Bridgeport, CT; Phoenix, AZ;[24] Providence, RI; St. Louis, MO; Tulsa, OK; and West Palm Beach, FL. The primary venues for conducting the surveys were Volunteer Income Tax Assistance (VITA) sites either run by or associated with the local research partner participating in this project. VITA programs offer free tax help to people whose incomes were $36,000 or less in 2004. They are generally located at community and neighborhood centers, libraries, schools, shopping malls and other convenient locations. In some instances (St. Louis, Des Moines, Tulsa and West Palm Beach), surveys were done at more than one VITA site. In four sites (Atlanta, Bridgeport, Phoenix and Providence), field organizers for ACORN—the local research partner in these locations—conducted some surveys by going door-to-door in the community. (All of the Atlanta surveys were collected in this fashion.) The surveys not collected at VITA sites have been excluded from the aggregate data reported here, and the analysis of the aggregate data that follows encompasses seven of the eight cities. The section that reports site-specific findings includes all of the data.

The survey was conducted between January and April 2005 using a written questionnaire developed by The Access Project and the local partner organizations. To minimize selection bias, every person who registered for tax assistance at a VITA site during a time the survey was being conducted was asked to participate, and was assured both of confidentiality and that declining participation would not affect the receipt of services. The questionnaire was either administered by a surveyor who had been trained on this specific instrument or was self-administered by the respondent, with trained surveyors nearby to supply needed clarifications. Information supplied for the survey was self-reported and not verified with other sources. The questionnaires were available in English and Spanish.

The VITA sites were chosen as the main venue for this survey because they provided a reliable pool of low- and moderate-income working people who are especially vulnerable to the hazards of medical debt.

Many people who seek tax assistance at VITA sites do so in order to claim the Earned Income Tax Credit (EITC) and receive a refund without incurring the expense of a commercial tax preparer.[25] The credit is available to people with income from wages up to a certain level—about $35,000 in tax year 2004 for families with more than one child, and somewhat less for families with one or no children. The maximum credit in 2004 was $4,300 for workers with two or more children, $2,604 for workers with one child, and $390 for workers not raising a child; the average EITC in 2003 was $2,100. If the credit exceeds a family's tax liability, that excess is refunded to the family as a direct payment.[26]

A total of 2,136 surveys were completed. Of that total, 1,692 (79%) were completed at VITA sites and 444 (21%) were collected through door-to-door canvassing.

IV. Survey Findings[27]

Demographic Characteristics of Survey Respondents

The VITA site sample was racially and ethnically diverse. Of the 1,692 survey respondents, about a third (34%) of the survey respondents were African-American, 29 percent were white, 3 percent were American Indian and 2 percent were Asian or Asian-American. Fourteen percent identified themselves as Hispanic (of any race). Just under one-fifth (18%) of respondents did not identify a race or ethnicity.

Sixty-nine percent of the sample were not married; 31 percent were married. Households had an average of about 1.6 children, 28 percent had no children, 28 percent had one, and 45 percent had two or more. A large majority (91%) of respondents were under age 65.

Because many people use the VITA sites to claim the Earned Income Credit, we assumed that survey respondents would fall largely within the income range eligible for the credit. This proved to be the case: 38 percent of the sample had incomes below $15,000, 34 percent between $15,000 and $25,000, and 20 percent between $25,000 and $35,000. Only eight percent of our sample had incomes over $35,000, beyond the range of eligibility for the tax credit.

To determine whether our sample was representative of a larger national group of low-income families, we compared the demographics of our sample with national data on tax filers who claim the earned income credit. In general, the incomes of our sample were slightly higher, there was a somewhat higher proportion of childless families (though a vast majority—73 percent—had children), and respondents to our survey were more likely to be married than the typical EITC recipient. In short, our sample is slightly better off economically than the EITC population overall, suggesting the possibility that the sample's experience with medical debt would understate the experience of a typical EITC family. (See Table 1)

Table 1. Demographics of Survey Respondents

	% of VITA site sample[1]	% of EITC tax filers nationally[2]
Race/Ethnicity		
African-American	34	
White	29	
Hispanic (any race)	14	
American Indian	3	
Asian/Asian American	2	
2 or more races	1	
Race unknown	18	
Age		
Under 65	91	
65 and older	9	
Marital Status		
Married	31	22
Unmarried	69	78
Number of Children		
Average	1.6	
Zero	28	19
One	28	39
Two or more	45	42
Income		
Less than $15,000	38	55
$15,000 to less than $25,000	34	30
$25,000 to less than $35,000	20	
$25,000 and above	28	15
$35,000 and above	8	

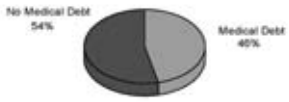
Sources

[1]The Access Project medical debt and housing survey, 2005.

[2]Income and number of children: Internal Revenue Service, Statistics of Income Division, Publication #1304, Tax Year 2002. Marital status: Carasso and Steuerle, "Projected Distribution of EITC Claims in 2003." Urban Institute and Brookings Institution Tax Policy Center, 7/19/2004.

Fig. 1

Prevalence of Medical Debt



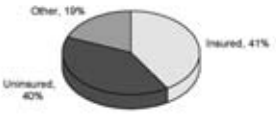
n = 1,692

Medical Debt

Prevalence and sources of debt Of the 1,692 in the sample, nearly half (46%) of survey respondents reported having medical debt (Fig. 1). Slightly more respondents with debt said they had health insurance than not at the time they received the care for which they owe money (Fig. 2). Most of the people with debt (70%) owed hospitals and nearly half (44%) owed doctors. Smaller but significant numbers owed many other types of medical providers (Fig. 3). Even aside from hospital bills, 74 percent of survey respondents with medical debt owed other providers; 27 percent owed more than two types of providers.

Fig. 2

Many with Medical Debt Were Insured at Time of Bill

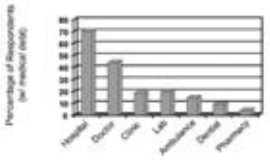


"Other" includes both Don't Know and family with both insured and uninsured among members with medical debt

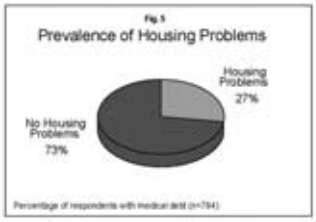
Characteristics of debtors Though there were variations in medical debt by race and ethnicity, the more important finding is that all racial and ethnic categories were substantially affected. Among the respondents who identified their race or ethnicity, Asian Americans (53%), African Americans (52%) and Hispanics of any race (50%) were most likely to report having medical debt. The lowest incidence of medical debt was among American Indians, but at 40 percent the proportion was still high.[28] People at various income levels—at least in the range covered by the survey—were also similarly affected. Between 43 and 49 percent of people in all income classes—from below $15,000 to over $35,000—said they had medical debt.

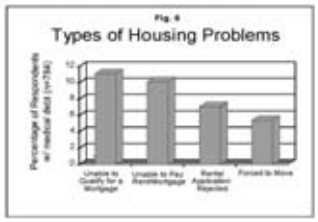
Fig. 3

Where is Medical Debt Owed?



Non-elderly people were much more likely to face the burdens of medical debt than people age 65 and above (47% vs. 29%). Possible explanations for this is that programs for seniors such as Medicare are largely effective in protecting them from financial difficulties, and that seniors are relatively insulated from cutbacks in private insurance or state Medicaid programs that provide the bulk of coverage to younger people.





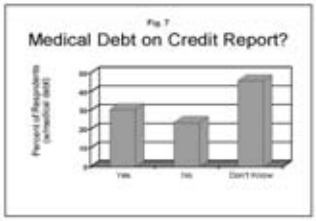
Financial assistance for debtors Three-quarters of respondents with medical debt (78%) received no offers of financial assistance from their medical providers. Of those who did, the most common forms of assistance were a payment plan over time or information about public programs to which they might apply. Only six percent said they had been offered a discount on their bill (Fig. 4).[29]

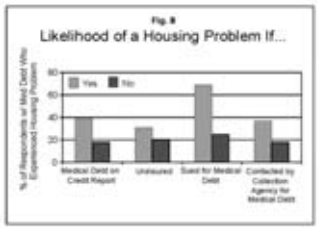
Housing Problems and Financial Effects of Medical Debt

Existence of housing problems More than one quarter (27%) of survey respondents with medical debt said they had housing problems that resulted from the debt (Fig. 5). The most common problems were inability to qualify for a mortgage (11%), inability to pay rent or mortgage (10%), being turned down from renting a home (7%), and being forced to move to less expensive housing (5%) (Fig. 6). A small number of respondents said that they were evicted (2%) and/or were now homeless (2%) because of medical debt.

Significance of health insurance Respondents without health insurance were more likely to have larger debts; about 38 percent of respondents with health insurance at the time they acquired medical debt had debts smaller than $500. Among those with debt, those who were not insured were more likely to say that the debt led to a housing problem. But a significant number—about one in five—of those who had been insured experienced housing problems as well (Fig. 8).

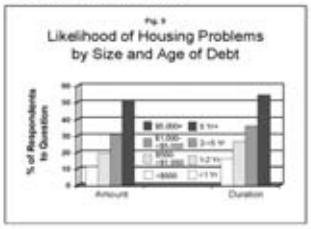
Relationship between credit reporting and housing problems Many respondents with medical debt did not know whether the debt was included in their credit report (46%). Of those who did know, nearly three in five said that it was included (Fig. 7). These people were twice as likely to report having housing problems than those who reported that their medical debt was not on their credit report (39% versus 18%; Fig. 8).





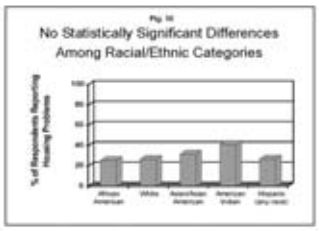
The survey suggests that debt does not have to be particularly large nor particularly old to affect one's credit standing. While larger debts were more likely to appear on a credit report (77% of debts greater than $1,000), smaller debts can harm credit as well. About one in six respondents (16%) who said medical debt was on their credit report had debts under $500, and over one-third (35%) had debts under $1,000. Similarly, while medical debt older than one year was highly likely (78%) to be on a credit report, a quarter of debts (23%) less than a year old were reported as well.

Relationship between characteristics of debt and income with housing problems The amount of outstanding medical bills was distributed fairly evenly from relatively low (less than $500) to very high ($5,000 or more), with bills in the $1,000 to $5,000 range most common. About half (52%) of people with outstanding bills of $5,000 or more reported having a housing problem resulting from medical debt. While people with larger bills were more likely to face a problem, those with much smaller bills were not immune: 12 percent of respondents with medical debts of less than $500 reported housing problems as well (Fig. 9).



Longer-term medical debt was more strongly associated with housing problems than shorter-term debt. Over half (55%) of respondents with debt more than five years old reported housing problems. Still, 16 percent of those with debt less than a year old reported problems as well (Fig. 9).

Income level also appeared to have little association with resulting housing problems. Similarly, all racial and ethnic groups reported a substantial level of housing problems; there were no statistically significant differences[30] among them (Fig. 10).



Relationship between collection actions and housing problems Half of respondents with medical debt (50%) had been contacted by collection agencies. Five percent had been sued for the debt. People who had been contacted by collection agencies or who had been sued were more likely to report that the debt resulted in housing problems (Fig. 8) than those who had not. There was also an association between housing problems and actions resulting from legal judgments such as home liens, other property liens, and wage garnishment but the numbers of people who experienced these actions were small in the survey sample.

Bankruptcy was a minor effect of medical debt in this survey, relative to other consequences; seven percent said they had filed personal bankruptcy since owing money for medical bills. This is not out of line with the rate of personal bankruptcy nationally, however: about 1.5 percent of U.S. households declare bankruptcy each year.[31]

PERSONAL ACCOUNT

Insured, in debt, and forced to move

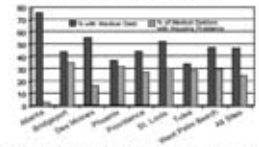
Nancy, a resident of Scottsdale, Arizona, is a mother of two and grandmother of one. In late 2002, while taking care of her ailing mother who was suffering from dementia and vascular disease, Nancy was diagnosed with colon cancer. Although she had medical insurance through her late husband's retiree benefits, the costs of surgery and chemotherapy were only partially covered by the health care plan. In addition to Nancy's own medical bills of about $12,000, the cost of her mother's nursing home stay and respite care totaled over $30,000. After her mother's death, Nancy was unable to make mortgage payments on her parents' house and was forced to sell the home to avoid foreclosure. Unable to afford rent on her own, Nancy has since moved into her sister and niece's two-bedroom apartment where one of them has to sleep on the couch each night. Even after selling the house, in addition to $3,678 of her own medical debt, Nancy still has upwards of $20,000 in medical debt for her mother's care on her credit card. Nancy was advised to file for bankruptcy, but when she investigated she determined she could not afford to hire a lawyer to file the case. She says that she has learned to live with bill collectors constantly pestering her at home trying to collect her debts.

Site-Specific Findings

Medical debt and resulting housing problems were frequent in every site that participated in the survey. A table containing site-specific findings appears in Appendix B. This table incorporates the data collected through door-to-door surveying, in addition to the surveys from the tax assistance sites (see "Methods" section). Some of the key findings follow:

- Atlanta had the highest prevalence of medical debt, Tulsa and Phoenix the lowest (Fig 11).
- Medical debt was fairly evenly distributed across income categories in most sites. The exception was Bridgeport, where medical debt was more likely for lower income respondents.
- Asian Americans reported a disproportionately high level of medical debt in Des Moines and Tulsa. Respondents of Hispanic descent had a disproportionately high level of medical debt in Palm Beach and Tulsa, but reported medical debt at a low rate in St. Louis. Respondents who identified themselves as being of more than one race had higher levels of medical debt in Tulsa.
- With the exception of Atlanta, at least one out of six respondents with medical debt in each site reported that the debt resulted in a housing problem. Bridgeport respondents most frequently (36%) said the debt resulted in a housing problem. At other sites the proportion ranged from 16 to 31 percent (Fig 11).
- Respondents in most sites reported they were insured at the time the debt was incurred about half the time (Phoenix, Palm Beach, Providence, Tulsa) or more (Atlanta, Bridgeport, St. Louis). Four of ten respondents in Des Moines said they were insured.
- Medical debt was commonly reported to be on credit reports. At least four in ten respondents (Tulsa) and as many as eight in ten (Atlanta) said the debt was on their credit report.
- Respondents in four sites (Atlanta, Palm Beach, Providence, St. Louis) were more likely than not to say they were contacted by a collection agency about their medical debts, and were about equally likely as not in two sites (Bridgeport, Tulsa). A minority of respondents in Des Moines (30%) and Phoenix (44%) said they were contacted.

Fig. 11
Prevalence of Medical Debt and Housing Problems, by Site



V. Discussion

This large-scale survey, conducted in eight locations across the country, verifies a central finding of a number of recent studies: medical debt is a common phenomenon. In this case, it was present among nearly half of the survey respondents, most of whom were low and moderate income, working age adults. Many of these adults were present where the surveys were conducted—volunteer tax assistance centers—because they had employment income and were eligible for the federal Earned Income Tax Credit. A majority had health insurance at the time they acquired the debt. Most had children living with them. In short, working families of modest means are at high risk for medical debt and its attendant consequences. Past research indicates that these consequences include restricted access to medical care for all family members, depletion of savings, and harassment by collection agencies, all of which constitute barriers to economic advancement and healthier and more secure lives.

Housing and credit problems

The survey also introduces new information about consequences of medical debt. A quarter of the respondents with debt said they had experienced some type of housing problems as a result of it. These problems include being unable to qualify for a mortgage, to make mortgage or rent payments, to rent a home, or the need to move to a less costly home. These findings establish medical debt as a barrier to still other important elements of economic advancement, namely asset development and housing security.[32]

An analysis of the demographic and financial characteristics of the survey respondents whose medical debt led to housing problems suggests that the risk of such an outcome is widespread. A significant portion of respondents with medical debt—regardless of their age, income, marital status and ethnicity—had housing problems as a result. Within the scope of this survey, no group appears to have been invulnerable to the effects on housing situations of medical debt.

That medical debt commonly leads to housing problems in this study should not be a surprise given the general prevalence of medical debt among low and moderate income families, who tend not to have much money to spare for unplanned expenses. What is sobering is that even relatively small levels of medical debt—$500 or less—can create housing and other economic hardships for families. These disadvantages seem out of proportion with the modest debt that brings them on, and $500 may constitute a significant percentage of family income. An additional finding is that housing problems become more likely as medical debt lingers.

Some of the housing problems reported in this study simply reflect the fact that medical debt, because it lays a claim to families' available resources, diminishes the amount available to use for other purposes, such as rent payments or home maintenance. Other problems, however, are indicative of deeper issues. The inability to qualify for a mortgage or even to rent an apartment, for example, is a signal of damaged credit, which has broad ramifications.

Medical debt affected the credit of at least a third of the survey respondents with debt, and these people were more than twice as likely as those whose medical debt did not mar their credit to report a housing problem. This is especially significant because nearly half of those surveyed said they did not know whether medical debt was on their credit report. Our findings suggest that those who are not yet aware of their credit status are more likely than not to find their credit hurt—an unwelcome surprise when trying to buy a home or access other credit.

The importance of credit reporting

Barriers to obtaining housing are but one way that damaged credit affects people's lives. It also limits access to affordable credit for other purposes, such as purchasing a car, which may in turn limit employment possibilities. Employers may themselves consult credit reports in making hiring decisions. Insurers may consult credit reports in underwriting automobile and home coverage. In some cases, people with low credit scores have been required to pay higher utility deposits. And the effects of damaged credit linger; a delinquent account, regardless of size, can remain on a credit report for seven years.[33] This risk is often multiplied by the fact that a single medical episode can result in many bills—from a hospital, doctor, ambulance, laboratory, and so on—and, therefore, many scars on a credit report.

Unlike many other types of debt, medical debt usually can only harm a credit rating, not help it. When medical providers and their collection agents report debt to credit bureaus, they typically do so only when payments have not been made. This negative-only treatment of medical debt is all the more inequitable because it is one of the few types of debt that are involuntarily acquired. Thus this "accidental debt," even if relatively small, essentially acts as a sickness tax—on top of the bills themselves and possible lost employment income—by damaging credit. And this tax is long-term, perhaps permanent.

Inadequacy of insurance "protection"

One other finding deserves specific attention. Having health insurance did not provide adequate protection from housing problems in many cases of medical debt, although those who did not have health insurance at the time their medical debt was incurred were more likely to experience housing problems. And, although the debts of those who had health insurance tended to be smaller, even small amounts could damage their credit status. According to information from other sources, families with incomes below twice the federal poverty line (about $36,800 for a family of four) had out-of-pocket health care expenses of about $2,800 in 2002,[34] about 7.6 percent of income for a typically-sized family. Added to this, a debt of even $500—another 1.4 percent of income—is significant. Seen in this context, the burden is clear.

That health insurance seems not to have served its fundamental purpose for many survey respondents—protecting families against great financial exposure—warrants further attention. The current trend of passing more of the financial burden of health care to individuals through higher deductibles and copayments in the name of "individual responsibility," combined with rapidly increasing health care costs, particularly for the chronically ill, raises crucial questions about the deteriorating adequacy of insurance that should be addressed in the policy arena.

VI. Policy Recommendations

So what can be done? The effects uncovered in this survey are likely only to worsen as health care costs increase, the numbers of uninsured rise, and those fortunate enough to maintain health coverage are required to absorb more of the cost. Medical debt is affecting people's access to housing at the same time that housing is becoming increasingly unaffordable for families of modest means,[35] and the medically-related credit problems that cause these housing problems hinder families' economic advancement in many other ways.

Legislators and other policy makers, as well as members of the sectors that contribute to this problem—medical providers, health insurers, employers and lenders—should consider a number of areas in which they might respond to reduce the sickness tax that medical debt imposes. If the market and private actions are unable to relieve the problem, legislation or regulation requiring some of these changes would be an appropriate next step.

Medical Providers

Medical providers can contribute to solving the problem by reducing the amount of medical debt they create, and by changing practices that result in additional financial difficulties for patients. For example, publicity in the last few years about hospitals' practices of billing uninsured patients their highest fees and pursuing them using overly-aggressive collection practices have led to greater attention to charity care and collections policies. Some hospitals have revamped their practices by offering greater discounts to low-income uninsured patients and restricting practices like wage garnishments and property liens.[36] Still, many hospitals have not addressed their policies at all, and some that have are not making their policies well known to the general public.[37] Hospitals can also limit the creation of medical debt—and enhance their revenues—by adequately screening patients for eligibility in public insurance programs such as Medicaid, and by agreeing to reasonable payment plans that low-income patients can fulfill.

The significant numbers of respondents in this study who reported debt to doctors and other non-hospital providers also remind us that these other providers have not been held to account on this issue to the same extent as hospitals. Further scrutiny and standards regarding providers' relationships with collection agents, lenders and credit bureaus would bring focus to additional policy solutions.

Insurers and Employers

That people with health insurance are affected by medical debt and its consequences almost to the same degree as those without calls into question the adequacy of some insurance in protecting policy holders from financial catastrophe. New developments in health insurance products—health savings accounts, high deductible plans, limited benefit policies, "consumer-driven health care"—put families with little excess income at risk and challenge the very notion of health insurance. (Many of these plans have deductibles of $1,000 or more, well above the level of debt that harmed the

respondents in our study.) Employers who want to continue offering coverage to their employees in the face of ever-rising premiums often have little choice but to pass along more of the cost of the coverage, increasing the risk of medical debt for their employees. Little has been demanded of insurers, however, many of which have enjoyed robust profits in the last few years.[38] Standards for adequate coverage, including cost sharing obligations that are proportionate to family incomes, might be explored, as well as programs to provide benefits to the communities in which insurers operate. This year, for example, the four Pennsylvania Blue Cross plans agreed to create a "Community Health Reinvestment Fund," which could blaze a trail for the recognition of insurers' community obligations elsewhere.[39]

Further research is also needed to understand the relative influences of various shortcomings in health insurance—excessively high deductibles, breaks in coverage, uncovered services—on medical debt and its resulting problems. Knowledge of this sort will help policy makers determine how to set standards for adequate coverage, so that the purpose of health insurance as financial protection might be restored and maintained.

PERSONAL ACCOUNT

Insurance without protection: on-going health costs lead to foreclosure

Beverly always dreamed of becoming financially independent so she could support herself after retirement. When she was diagnosed with kidney cancer three years ago and thyroid cancer a year and a half later, medical expenses made this dream unattainable.

Beverly is a 58 year-old woman who has one son and three grandchildren. For the past nineteen years, she has worked as the office secretary at a union, the Communications Workers of America, in St. Louis, Missouri. Despite consistent health insurance coverage, the costs of cancer treatment have kept Beverly in a state of perpetual debt. In addition to a $1,500 per year deductible, Beverly must advance out of her own pocket the very high costs of necessary procedures, such as CAT scans, as well as her prescription medications. As soon as the health plan reimburses her for these costs, she must pay again for the next round of treatments and procedures. Due to these soaring medical expenses, Beverly was unable to keep up with the mortgage payments on the house she owned for twenty years; she lost her home to foreclosure and moved in with her recently widowed mother. Beverly's doctors recommend that she remain stress-free, take time off from work, or work part time. Unfortunately, to maintain her insurance coverage and income level, she has no choice but to work full time.

Lenders and Affiliated Organizations

A consensus appears to exist among those who make and advise others about lending decisions that medical debt should be considered differently from other types of personal debt. Fair Isaac and Company (FICO), a major credit scoring organization, considers medical debt to be "atypical and non-predictive" of overall credit worthiness, for example.[40] While lenders might reasonably be asked to develop explicit policies for segregating medical debts in considering an applicant's eligibility for credit, such an approach presumes that medical debt is readily identifiable as such on a credit report. If a delinquent account is listed by the name of a collection agency rather than a medical provider, or if a bill has been paid with a credit card or at the expense of another bill that therefore replaces the delinquent medical bill, medical debt might not be identifiable as such. Lenders, who might like to discount or disregard medical debt in their decision making thus often do not have sufficient information to implement such policies.

Given the atypical nature of medical debt and the commonly expressed policy to treat it differently, one might question the need for health care providers to report these debts to credit bureaus at all. Lenders, creditors, credit bureaus and regulators should consider ways to prevent medical debt from ever tarnishing a credit record, including rules to prohibit medical providers and their agents from reporting medical debt to credit agencies.

A consensus appears to exist among those who make and advise others about lending decisions that medical debt should be considered differently from other types of personal debt

VII. Conclusion

If there is a more vulnerable circumstance for a person to be in than being ill, it is probably to be ill and in debt. This report has shown that such vulnerability is not rare among our survey respondents. To compound this, medical debt often results in housing and credit problems, which may in turn bring about further crippling financial difficulties.

Repairing the health care system—controlling costs, improving quality, ensuring access and eliminating disparities—is a challenge of national scope that has, to date, been maddeningly elusive. Smaller victories are achievable, however. One place to look is eliminating the financial penalty imposed on people for getting sick. Remedies—on the part of policy makers, medical providers, insurers and lenders—are at hand. All that is needed is action.

Appendices

Appendix A

Tables Showing Aggregate Data

The following tables reported data collected only at the Volunteer Income Tax Assistance (VITA) sites (n=1,692). See the "Methods" section of the report for further explanation.

Table A1.
Respondents with Medical Debt

All Respondents	1,692
Number with Medical Debt	784
Percentage with Medical Debt	46.3
Of Respondents with Medical Debt:	
Health Insurance at time debt acquired	
Yes	41.0 %
No	40.1
Other*	8.9
Type of provider owed	
Hospital	70.3
Doctor	44.3
Clinic	18.7
Lab	19.8
Ambulance	14.9
Dentist	9.4
Pharmacy	4.2
Provider offered financial assistance	
No offer	77.7
Payment plan over time	13.6
Informed of public programs	7.5
Discount on bill	5.5
Help applying for loan	1.3
Amount of debt	
< $500	28.7
$500-< $1,000	21.9
$1,000-< $5,000	33.8
$5,000 +	15.6
How long had debt	
< 1 year	36.4
1 to 2 years	36.4
> 2 but < 5 years	18.7
5 years or more	8.6

*Includes both "Don't Know" and families with both insured and uninsured among family members with medical debt.

Table A2.
Housing Problems and Other Financial Effects of Medical Debt

Respondents with Medical Debt	784
Number of Med. Debtors with Housing Problems	213
Percentage of Medical Debtors with Housing Problems	27.2
Type of Housing Problem	
- Unable to qualify for mortgage	11.1%
- Unable to pay rent or mortgage	10.3
- Rental application rejected	6.6
- Forced to move to less expensive housing	5.4
- Unable to do home repair/maintenance	4.1
- Unable to pay property taxes	2.6
- Unable to mainain housing, now homeless	2.2
- Refinanced/took second mortgage to pay bills	1.9
- Evicted	1.7
Medical debt on credit report	
- Yes	30.6
- No	23.5
- Don't know	45.9

Table A3.
Association between Housing Problems and Selected Characteristics

	% w/housing problems
Health insurance at time of debt	
Yes	30.9
No	20.3
Medical debt on credit report	
Yes	39.4
No	17.5
Amount of debt	
< $500	12.0
$500- < $1,000	19.9
$1,000- < $5,000	31.6
$5,000 +	51.9
How long had debt	
< 1 year	16.5
1 to 2 years	27.1
> 2 but < 5 years	36.6
5 years or more	55.0
Income	
Less than $15,000	29.2
$15,000 to less than $25,000	27.2
$25,000 to less than $35,000	30.5
$35,000 and above	17.3
Race/Ethnicity	
African-American	25.5
White	26.5
American Indian	41.2
Asian/Asian American	31.6
Hispanic (any race)	27.0
2 or more races/race unknown	30.0
Contacted by collection agency	
Yes	36.8
No	17.7
Sued in small claims court	
Yes	69.0
No	24.8

Appendix B

Site-Specific Data

This table presents all of the survey data collected for the survey, from both the VITA sites (n1=1,692) and through door-to-door canvassing (n2=444; Total N= 2,136). See "Methods" section of report for further explanation.

	Atlanta	Bridgeport	Des Moines	Phoenix	Providence	St. Louis	Tulsa	West Palm Beach
Number of surveys	154	151	291	415	88	383	257	397
Percentage with Medical Debt	76%	44%	55%	36%	43%	53%	35%	48%
by income:								
<$15,000	65%	56%	56%	31%	50%	56%	37%	47%
$15,000-$25,000	82%	45%	52%	41%	55%	51%	27%	62%
$25,001-$35,000	80%	41%	55%	37%	*	48%	36%	48%
>$35,000	70%	33%	58%	32%	*	56%	31%	50%
by race/ethnicity:								
African American	74%	48%	52%	35%	50%	56%	32%	56%
White	*	36%	58%	40%	41%	48%	34%	46%
Asian/Asian American	*	*	67%	*	*	*	45%	*
American Indian	*	*	*	*	*	*	28%	*
Hispanic (any race)	82%	39%	48%	39%	36%	38%	45%	60%
Multiple races/Other	*	47%	*	34%	45%	57%	47%	27%
Percentage with Med. Debt who reported:								
Housing problem due to medical bill	3%	36%	16%	31%	26%	31%	29%	30%
Medical debt on credit report	82%	59%	49%	65%	50%	57%	41%	71%
Insured at time debt acquired	64%	59%	39%	49%	52%	64%	49%	47%
Contacted by collection agency	71%	49%	30%	44%	71%	55%	48%	60%
Sued for debt	3%	13%	4%	5%	13%	6%	7%	2%
Bankruptcy	14%	6%	3%	9%	3%	9%	6%	5%

*Fewer than 10 cases in category

Endnotes

[1] Bridgeport, Connecticut; Des Moines, Iowa; Phoenix, Arizona; Providence, Rhode Island; St. Louis, Missouri; Tulsa, Oklahoma; and West Palm Beach, Florida.

[2] For example, 55 percent of people in a national poll said that uninsured people are still able to get the medical care they need from doctors and hospitals. Kaiser Family Foundation Health Poll Report, July 2001.

[3] Dennis Andrulis, Lisa Duchon, Carol Pryor and Nanette Goodman, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?* The Access Project, 2003.

[4] *The Consequences of Medical Debt: Evidence from Three Communities*. The Access Project, 2003; Carol Pryor and Deborah Gurewich, *Getting Care but Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices*. The Access Project, 2004.

[5] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills." The Commonwealth Fund, August 2005.

[6] USA Today/Kaiser Family Foundation/Harvard School of Public Health, *Health Care Costs Survey*, August 2005.

[7] For example, National Public Radio/Kaiser Family Foundation/John F. Kennedy School of Government, *National Survey on Health Care*, 2002.

[8] Andrulis et al., *Paying for Health Care When You're Uninsured*.

[9] Deborah Gurewich, Jeffrey Prottas, Robert Seifert and Susan Seager, "Medical Debt and Consumer Credit Counseling Services." *Journal of Health Care for the Poor and Underserved* 15:3 (August 2004).

[10] $36,800 for a family of four in 2003, when the survey reporting these data was conducted.

[11] Doty et al.

[12] Doty et al.

[13] Cathy Schoen, Michelle M. Doty, Sara R. Collins and Alyssa L. Holmgren, "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs Web Exclusive*, June 2005. An "underinsured" adult is defined in this study as one with health insurance whose family out-of-pocket medical expenses represent 10% or more of income or 5% or more of income in low- income families, or whose deductible represents 5% or more of income. It probably underestimates the number of people whose insurance is inadequate because some of the criteria reflect policies that have actually failed to protect and not those that potentially fail to protect.

[14] Doty et al.

[15] David Himmelstein, Elizabeth Warren, Deborah Thorne and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy." *Health Affairs Web Exclusive*, February 2005.

[16] Andrulis et al.

[17] Pryor and Gurewich, *Getting Care but Paying the Price*.

[18] Schoen et al.

[19] Jennifer Steinhauer, "Will Doctors Make Your Credit Sick?" *New York Times*, February 4, 2001, p. B13.

[20] Doty et al.; Himmelstein et al.; Rachel Banov, "The Effect of Health Insurance on Savings Outcomes in Individual Development Accounts." Center for Social Development, Washington University, 2005.

[21] Grace Rollins, *Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices*. Connecticut Center for a New Economy, January 2003; Lucette Lagnado," Twenty Years and Still Paying," *The Wall Street Journal*, March 13, 2003.

[22] Lucette Lagnado, "Hospitals Try Extreme Measures to Collect Their Overdue Debts," *The Wall Street Journal*, October 30, 2003.

[23] Himmelstein et al., op. cit.

[24] Actual surveying was done in Mesa and Glendale, communities in the Phoenix metropolitan area.

[25] Robert Greenstein, "The Earned Income Tax Credit: Boosting Employment, Aiding the Working Poor." Center on Budget and Policy Priorities, July 2005.

[26] Center on Budget and Policy Priorities, "Facts About the Earned Income Credit." http://www.cbpp.org/eic2005/eic05-factbook.pdf, accessed August 15, 2005.

[27] The bulk of findings reported here are from the VITA subsample of 1,692 respondents. The "Site-Specific Findings" section reports on the full sample of 2,136.

[28] Forty-four survey respondents identified themselves as American Indian.

[29] The survey did not ask whether the original bill may have reflected a sliding fee scale based on a person's income. To the extent that was the case, this statistic may underreport the percentage of people who received a discount on their bill.

[30] $p < 0.1$

[31] Calculation based on data from the U.S. Bankruptcy Court and the U.S. Bureau of the Census.

[32] Home ownership has been shown to be a major instrument of wealth accumulation for middle class families, as well as having significant inter-generational effects for low-income families, such as the increased likelihood of a homeowner's children owning homes themselves and having higher incomes and more advanced education. See, for example, Thomas P. Boehm and Alan M. Schlottmann, "Housing and Wealth Accumulation: Intergenerational Impacts." *Low-Income Homeownership Working Paper Series*, Joint Center for Housing Studies of Harvard University, October 2001.

[33] Fair Credit Reporting Act, 15 U.S.C. §1681c

[34] Stephen R. Machlin and Marc W. Zodet, "Family Health Care Expenses, by Income Level, 2002." Agency for Healthcare Research and Quality, Statistical Brief #64, January 2005.

[35] "U.S. Housing Prices Rise 20 Percent Nationwide, While Wages for Key Community Workers Remain Relatively Flat." Center for Housing Policy press release, August 9, 2005. http://www.nhc.org/index/News-PR-Center05P2P-080905, accessed August 15, 2005.

[36] The Healthcare Financial Management Association's "Patient-Friendly Billing" project (www.patientfriendlybilling.org) has provided valuable leadership to hospitals on these issues.

[37] Bill Lottero and Carol Pryor, *Voluntary Commitments*. The Access Project, May 2005.

[38] For example, the Indianapolis Business Journal (Sept. 5, 2005) reported an analyst's estimate that WellPoint will earn profits of $2.5 billion this year, on revenues of $45 billion; UnitedHealth Group's corporate filings indicate a 30% increase in profits from the second quarter of 2004 to the second quarter of 2005; Humana also reported a 30% increase for the first half of 2005.

[39] Bill Toland, "Blues insurers helping fund programs that provide health coverage to poor." *Pittsburgh Post-Gazette*, February 8, 2005.

[40] Robert W. Seifert, "The Demand Side of Financial Exploitation: The Case of Medical Debt." *Housing Policy Debate* 15:3 (2004).

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Fact Sheet on Medical Debt
The Access Project
July 17, 2007

What is Medical Debt?
Medical debt is money owed for any type of medical services or products. The money may be owed directly to the provider of the service or to an agent of the provider, such as a collection agency. When money is borrowed for the purpose of paying off medical bills, it is also considered medical debt.

How Many Americans Have Medical Bill Problems and Medical Debt
- One third (34%) of adults under the age of 65 have problems related to medical bills or accrued medical debt. Over half (53%) of uninsured adults and more than a quarter (26%) of continuously insured adults have this problem. [18][*]
- One in five adults (21%) under the age of 65 have current medical debt. [18]
- One quarter (25%) of non-elderly adults spend 10 percent or more of their household income on insurance premiums and out-of-pocket healthcare expenses. [17]
- An estimated 58 million adults are at risk of incurring medical bills they may not be able to afford. This includes 17.6 million privately insured adults. [20]

The Financial Consequences of Medical Debt
- One quarter (26%) of non-elderly adults with medical bill problems or medical debt were unable to pay for basic necessities. [18]
- Four in 10 (39%) non-elderly adults with medical bill problems or medical debt used up all of their savings to pay the bills. [18]
- One quarter (26%) of non-elderly adults with medical bill problems or medical debt took on credit card debt to pay the bills. [18]
- Among low and moderate income adults surveyed at income tax assistance sites, more than a quarter (27%) of those with medical debt said the debt caused housing problems, such as being unable to qualify for a mortgage or pay rent. [9]

Healthcare Access Consequences of Medical Debt
- Three of 10 non-elderly adults (29%) delayed or skipped needed care because of cost. [18]
- In a survey of community health center users in Massachusetts, nearly 60 percent of those with medical said it caused them to delay getting needed health care. [12]
- In a survey of family farmers in Kansas, nearly half (47%) of those with medical debt said it caused them to delay or avoid needed care. [6]
- The privately insured with medical debt are as likely to postpone care due to cost as the uninsured (28% and 30%), and much more likely to postpone care than the insured without medical debt (6%). [20]

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[*] The number refers to the number of the source publication, as listed on the back of this page.

Access Project Reports on Medical Debt

1. M. Rukavina et al, *Not Making the Grade: Lessons Learned from the Massachusetts Student Health Insurance Mandate*, 2007.
2. C. Pryor et al, *The Illusion of Coverage: How Health Insurance Fails People When They Get Sick*, 2007.
3. C. Zeldin et al, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses*, (with Demos), 2007.
4. S. Watson et al, *Living In the Red: Medical Debt and Housing Security in Missouri*, 2007.
5. R. Seifert et al, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, 2006. (Published in Health Affairs)
6. W. Lottero et al, *Losing Ground: Eroding Health Insurance Coverage Leaves Kansas Farmers with Medical Debt*, 2006.
7. C. Pryor et al, *Playing by the Rules but Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security*, 2006.
8. N. Kohn, *Heartache in the Heartland: Kansans Speak About the Burden of Medical Debt*, 2005.
9. R. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 2005.
10. D. Gurewich et al, *Medical Debt and Consumer Credit Counseling Services*, 2004 (Published in Journal of Health Care for the Poor and Underserved)
11. R. Seifert, *The Demand Side of Financial Exploitation: The Case of Medical Debt*, 2004 (Published in Housing Policy Debate)
12. C. Pryor et al, *Getting Care but Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices*, 2004.
13. C. Pryor et al, *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt*, 2003. (Published by The Commonwealth Fund)
14. R. Seifert, *The Consequences of Medical Debt: Evidence from Three Communities*, 2003.
15. D. Andrulis et al, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?*, 2003.

Other Reports on Medical Debt

16. ABC News/Kaiser Family Foundation/USA Today, *Health Care in America 2006 Survey: Chartpack*, October 2006.
17. S. Collins et al, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.
18. S. Collins et al, *Gaps in Health Insurance: An All-American Problem: Findings from the Commonwealth Fund Biennial Health Insurance Survey*, Commonwealth Fund, April 2006.
19. M. Merlis et al, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets*, The Commonwealth Fund, February 2006.
20. C. Hoffman et al, *Medical Debt and Access to Health Care*, Kaiser Commission on Medicaid and the Uninsured, September 2005.
21. M. M. Doty et al, *Seeing Red: Americans Driven into Debt by Medical Bills*, The Commonwealth Fund, August 2005.
22. C. Schoen et al, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs Web Exclusive*, June 2005.
23. D. Himmelstein et al, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs Web Exclusive*, February 2005.

BANKRUPTCY FORMS SUBMITTED BY THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN, CHAIRMAN, COMMITTEE ON THE JUDICIARY, AND MEMBER, SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE PROPERTY

Official Form 22C (Chapter 13) (04/07)

In re _____
Debtor(s)

Case Number: _____
(If known)

According to the calculations required by this statement:
☐ **The applicable commitment period is 3 years.**
☐ **The applicable commitment period is 5 years.**
☐ **Disposable income is determined under § 1325(b)(3).**
☐ **Disposable income is not determined under § 1325(b)(3).**
(Check the boxes as directed in Lines 17 and 23 of this statement.)

CHAPTER 13 STATEMENT OF CURRENT MONTHLY INCOME AND CALCULATION OF COMMITMENT PERIOD AND DISPOSABLE INCOME

In addition to Schedules I and J, this statement must be completed by every individual Chapter 13 debtor, whether or not filing jointly. Joint debtors may complete one statement only.

Part I. REPORT OF INCOME

		Column A Debtor's Income	Column B Spouse's Income
1	**Marital/filing status.** Check the box that applies and complete the balance of this part of this statement as directed. a. ☐ Unmarried. **Complete only Column A ("Debtor's Income") for Lines 2-10.** b. ☐ Married. **Complete both Column A ("Debtor's Income") and Column B ("Spouse's Income") for Lines 2-10.**		
	All figures must reflect average monthly income received from all sources, derived during the six calendar months prior to filing the bankruptcy case, ending on the last day of the month before the filing. If the amount of monthly income varied during the six months, you must divide the six-month total by six, and enter the result on the appropriate line.		
2	**Gross wages, salary, tips, bonuses, overtime, commissions.**	$	$
3	**Income from the operation of a business, profession, or farm.** Subtract Line b from Line a and enter the difference in the appropriate column(s) of Line 3. Do not enter a number less than zero. **Do not include any part of the business expenses entered on Line b as a deduction in Part IV.** a. Gross receipts $ b. Ordinary and necessary business expenses $ c. Business income Subtract Line b from Line a	$	$
4	**Rent and other real property income.** Subtract Line b from Line a and enter the difference in the appropriate column(s) of Line 4. Do not enter a number less than zero. **Do not include any part of the operating expenses entered on Line b as a deduction in Part IV.** a. Gross receipts $ b. Ordinary and necessary operating expenses $ c. Rent and other real property income Subtract Line b from Line a	$	$
5	**Interest, dividends, and royalties.**	$	$
6	**Pension and retirement income.**	$	$
7	**Any amounts paid by another person or entity, on a regular basis, for the household expenses of the debtor or the debtor's dependents, including child or spousal support.** Do not include amounts paid by the debtor's spouse.	$	$
8	**Unemployment compensation.** Enter the amount in the appropriate column(s) of Line 8. However, if you contend that unemployment compensation received by you or your spouse was a benefit under the Social Security Act, do not list the amount of such compensation in Column A or B, but instead state the amount in the space below: Unemployment compensation claimed to be a benefit under the Social Security Act: Debtor $ _____ Spouse $ _____	$	$
9	**Income from all other sources.** Specify source and amount. If necessary, list additional sources on a separate page. Total and enter on Line 9. **Do not include** any benefits received under the Social Security Act or payments received as a victim of a war crime, crime against humanity, or as a victim of international or domestic terrorism. a. $ b. $	$	$
10	**Subtotal.** Add Lines 2 thru 9 in Column A, and, if Column B is completed, add Lines 2 through 9 in Column B. Enter the total(s).	$	$
11	**Total.** If Column B has been completed, add Line 10, Column A to Line 10, Column B, and enter the total. If Column B has not been completed, enter the amount from Line 10, Column A.	$	

Part II. CALCULATION OF § 1325(b)(4) COMMITMENT PERIOD		
12	**Enter the amount from Line 11.**	
13	**Marital adjustment.** If you are married, but are not filing jointly with your spouse, AND if you contend that calculation of the commitment period under § 1325(b)(4) does not require inclusion of the income of your spouse, enter the amount of the income listed in Line 10, Column B that was NOT paid on a regular basis for the household expenses of you or your dependents. Otherwise, enter zero.	
14	**Subtract Line 13 from Line 12 and enter the result.**	
15	**Annualized current monthly income for § 1325(b)(4).** Multiply the amount from Line 14 by the number 12 and enter the result.	$
16	**Applicable median family income.** Enter the median family income for applicable state and household size. (This information is available by family size at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court.) a. Enter debtor's state of residence: _____ b. Enter debtor's household size: _____	$
17	**Application of § 1325(b)(4).** Check the applicable box and proceed as directed. ☐ **The amount on Line 15 is less than the amount on Line 16.** Check the box for "The applicable commitment period is 3 years" at the top of page 1 of this statement and continue with this statement. ☐ **The amount on Line 15 is not less than the amount on Line 16.** Check the box for "The applicable commitment period is 5 years" at the top of page 1 of this statement and continue with this statement.	

Part III. APPLICATION OF § 1325(b)(3) FOR DETERMINING DISPOSABLE INCOME		
18	**Enter the amount from Line 11.**	$
19	**Marital adjustment.** If you are married, but are not filing jointly with your spouse, enter the amount of the income listed in Line 10, Column B that was NOT paid on a regular basis for the household expenses of you or your dependents. If you are unmarried or married and filing jointly with your spouse, enter zero.	$
20	**Current monthly income for § 1325(b)(3).** Subtract Line 19 from Line 18 and enter the result.	
21	**Annualized current monthly income for § 1325(b)(3).** Multiply the amount from Line 20 by the number 12 and enter the result.	$
22	**Applicable median family income.** Enter the amount from Line 16.	$
23	**Application of § 1325(b)(3).** Check the applicable box and proceed as directed. ☐ **The amount on Line 21 is more than the amount on Line 22.** Check the box for "Disposable income is determined under § 1325(b)(3)" at the top of page 1 of this statement and complete the remaining parts of this statement. ☐ **The amount on Line 21 is not more than the amount on Line 22.** Check the box for "Disposable income is not determined under § 1325(b)(3)" at the top of page 1 of this statement and complete Part VII of this statement. **Do not complete Parts IV, V, or VI.**	

Part IV. CALCULATION OF DEDUCTIONS ALLOWED UNDER § 707(b)(2)		
Subpart A: Deductions under Standards of the Internal Revenue Service (IRS)		
24	**National Standards: food, clothing, household supplies, personal care, and miscellaneous.** Enter the "Total" amount from IRS National Standards for Allowable Living Expenses for the applicable family size and income level. (This information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court.)	$
25A	**Local Standards: housing and utilities; non-mortgage expenses.** Enter the amount of the IRS Housing and Utilities Standards; non-mortgage expenses for the applicable county and family size. (This information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court).	$

25B	**Local Standards: housing and utilities; mortgage/rent expense.** Enter, in Line a below, the amount of the IRS Housing and Utilities Standards; mortgage/rent expense for your county and family size (this information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court); enter on Line b the total of the Average Monthly Payments for any debts secured by your home, as stated in Line 47; subtract Line b from Line a and enter the result in Line 25B. **Do not enter an amount less than zero.** a. IRS Housing and Utilities Standards; mortgage/rent Expense $ b. Average Monthly Payment for any debts secured by your home, if any, as stated in Line 47 $ c. Net mortgage/rental expense Subtract Line b from Line a.	$
26	**Local Standards: housing and utilities; adjustment.** if you contend that the process set out in Lines 25A and 25B does not accurately compute the allowance to which you are entitled under the IRS Housing and Utilities Standards, enter any additional amount to which you contend you are entitled, and state the basis for your contention in the space below: _____ _____ _____	$
27	**Local Standards: transportation; vehicle operation/public transportation expense.** You are entitled to an expense allowance in this category regardless of whether you pay the expenses of operating a vehicle and regardless of whether you use public transportation. Check the number of vehicles for which you pay the operating expenses or for which the operating expenses are included as a contribution to your household expenses in Line 7. ☐ 0 ☐ 1 ☐ 2 or more. Enter the amount from IRS Transportation Standards, Operating Costs & Public Transportation Costs for the applicable number of vehicles in the applicable Metropolitan Statistical Area or Census Region. (This information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court.)	$
28	**Local Standards: transportation ownership/lease expense; Vehicle 1.** Check the number of vehicles for which you claim an ownership/lease expense. (You may not claim an ownership/lease expense for more than two vehicles.) ☐ 1 ☐ 2 or more. Enter, in Line a below, the amount of the IRS Transportation Standards, Ownership Costs, First Car (available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court); enter in Line b the total of the Average Monthly Payments for any debts secured by Vehicle 1, as stated in Line 47; subtract Line b from Line a and enter the result in Line 28. **Do not enter an amount less than zero.** a. IRS Transportation Standards, Ownership Costs, First Car $ b. Average Monthly Payment for any debts secured by Vehicle 1, as stated in Line 47 $ c. Net ownership/lease expense for Vehicle 1 Subtract Line b from Line a.	$
29	**Local Standards: transportation ownership/lease expense; Vehicle 2.** Complete this Line only if you checked the "2 or more" Box in Line 28. Enter, in Line a below, the amount of the IRS Transportation Standards, Ownership Costs, Second Car (available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court); enter in Line b the total of the Average Monthly Payments for any debts secured by Vehicle 2, as stated in Line 47; subtract Line b from Line a and enter the result in Line 29. **Do not enter an amount less than zero.** a. IRS Transportation Standards, Ownership Costs, Second Car $ b. Average Monthly Payment for any debts secured by Vehicle 2, as stated in Line 47 $ c. Net ownership/lease expense for Vehicle 2 Subtract Line b from Line a.	$
30	**Other Necessary Expenses: taxes.** Enter the total average monthly expense that you actually incur for all federal, state, and local taxes, other than real estate and sales taxes, such as income taxes, self employment taxes, social security taxes, and Medicare taxes. **Do not include real estate or sales taxes.**	$
31	**Other Necessary Expenses: mandatory payroll deductions.** Enter the total average monthly payroll deductions that are required for your employment, such as mandatory retirement contributions, union dues, and uniform costs. **Do not include discretionary amounts, such as non-mandatory 401(k) contributions.**	$

32	**Other Necessary Expenses: life insurance.** Enter average monthly premiums that you actually pay for term life insurance for yourself. **Do not include premiums for insurance on your dependents, for whole life or for any other form of insurance.**	$
33	**Other Necessary Expenses: court-ordered payments.** Enter the total monthly amount that you are required to pay pursuant to court order, such as spousal or child support payments. **Do not include payments on past due support obligations included in Line 49.**	$
34	**Other Necessary Expenses: education for employment or for a physically or mentally challenged child.** Enter the total monthly amount that you actually expend for education that is a condition of employment and for education that is required for a physically or mentally challenged dependent child for whom no public education providing similar services is available.	
35	**Other Necessary Expenses: childcare.** Enter the average monthly amount that you actually expend on childcare—such as baby-sitting, day care, nursery and preschool. **Do not include other educational payments.**	$
36	**Other Necessary Expenses: health care.** Enter the average monthly amount that you actually expend on health care expenses that are not reimbursed by insurance or paid by a health savings account. **Do not include payments for health insurance or health savings accounts listed in Line 39.**	$
37	**Other Necessary Expenses: telecommunication services.** Enter the average monthly amount that you actually pay for telecommunication services other than your basic home telephone service—such as cell phones, pagers, call waiting, caller id, special long distance, or internet service—to the extent necessary for your health and welfare or that of your dependents. **Do not include any amount previously deducted.**	$
38	**Total Expenses Allowed under IRS Standards.** Enter the total of Lines 24 through 37.	$

Subpart B: Additional Expense Deductions under § 707(b)

Note: Do not include any expenses that you have listed in Lines 24-37

39	**Health Insurance, Disability Insurance, and Health Savings Account Expenses.** List and total the average monthly amounts that you actually pay for yourself, your spouse, or your dependents in the following categories. a. Health Insurance $ b. Disability Insurance $ c. Health Savings Account $ Total: Add Lines a, b, and c	$
40	**Continued contributions to the care of household or family members.** Enter the actual monthly expenses that you will continue to pay for the reasonable and necessary care and support of an elderly, chronically ill, or disabled member of your household or member of your immediate family who is unable to pay for such expenses. **Do not include payments listed in Line 34.**	$
41	**Protection against family violence.** Enter any average monthly expenses that you actually incurred to maintain the safety of your family under the Family Violence Prevention and Services Act or other applicable federal law. The nature of these expenses is required to be kept confidential by the court.	$
42	**Home energy costs.** Enter the average monthly amount, in excess of the allowance specified by IRS Local Standards for Housing and Utilities, that you actually expend for home energy costs. **You must provide your case trustee with documentation demonstrating that the additional amount claimed is reasonable and necessary.**	$
43	**Education expenses for dependent children under 18.** Enter the average monthly expenses that you actually incur, not to exceed $137.50 per child, in providing elementary and secondary education for your dependent children less than 18 years of age. **You must provide your case trustee with documentation demonstrating that the amount claimed is reasonable and necessary and not already accounted for in the IRS Standards.**	$
44	**Additional food and clothing expense.** Enter the average monthly amount by which your food and clothing expenses exceed the combined allowances for food and apparel in the IRS National Standards, not to exceed five percent of those combined allowances. (This information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court.) **You must provide your case trustee with documentation demonstrating that the additional amount claimed is reasonable and necessary.**	$
45	**Continued charitable contributions.** Enter the amount that you will continue to contribute in the form of cash or financial instruments to a charitable organization as defined in 26 U.S.C. § 170(c)(1)-(2).	$
46	**Total Additional Expense Deductions under § 707(b).** Enter the total of Lines 39 through 45.	$

Subpart C: Deductions for Debt Payment

47 **Future payments on secured claims.** For each of your debts that is secured by an interest in property that you own, list the name of the creditor, identify the property securing the debt, and state the Average Monthly Payment. The Average Monthly Payment is the total of all amounts contractually due to each Secured Creditor in the 60 months following the filing of the bankruptcy case, divided by 60. Mortgage debts should include payments of taxes and insurance required by the mortgage. If necessary, list additional entries on a separate page.

	Name of Creditor	Property Securing the Debt	60-month Average Payment
a.			$
b.			$
c.			$
			Total: Add Lines a, b, and c

$

48 **Other payments on secured claims.** If any of debts listed in Line 47 are secured by your primary residence, a motor vehicle, or other property necessary for your support or the support of your dependents, you may include in your deduction 1/60th of any amount (the "cure amount") that you must pay the creditor in addition to the payments listed in Line 47, in order to maintain possession of the property. The cure amount would include any sums in default that must be paid in order to avoid repossession or foreclosure. List and total any such amounts in the following chart. If necessary, list additional entries on a separate page.

	Name of Creditor	Property Securing the Debt	1/60th of the Cure Amount
a.			$
b.			$
c.			$
			Total: Add Lines a, b, and c

$

49 **Payments on priority claims.** Enter the total amount of all priority claims (including priority child support and alimony claims), divided by 60. $

50 **Chapter 13 administrative expenses.** Multiply the amount in Line a by the amount in Line b, and enter the resulting administrative expense.

a.	Projected average monthly Chapter 13 plan payment.	$
b.	Current multiplier for your district as determined under schedules issued by the Executive Office for United States Trustees. (This information is available at www.usdoj.gov/ust/ or from the clerk of the bankruptcy court.)	x
c.	Average monthly administrative expense of Chapter 13 case	Total: Multiply Lines a and b

$

51 **Total Deductions for Debt Payment.** Enter the total of Lines 47 through 50. $

Subpart D: Total Deductions Allowed under § 707(b)(2)

52 **Total of all deductions allowed under § 707(b)(2).** Enter the total of Lines 38, 46, and 51. $

Part V. DETERMINATION OF DISPOSABLE INCOME UNDER § 1325(b)(2)

53 **Total current monthly income.** Enter the amount from Line 20. $

54 **Support income.** Enter the monthly average of any child support payments, foster care payments, or disability payments for a dependent child, included in Line 7, that you received in accordance with applicable nonbankruptcy law, to the extent reasonably necessary to be expended for such child. $

55 **Qualified retirement deductions.** Enter the monthly average of (a) all contributions or wage deductions made to qualified retirement plans, as specified in § 541(b)(7) and (b) all repayments of loans from retirement plans, as specified in § 362(b)(19). $

56 **Total of all deductions allowed under § 707(b)(2).** Enter the amount from Line 52. $

57 **Total adjustments to determine disposable income.** Add the amounts on Lines 54, 55, and 56 and enter the result. $

58	**Monthly Disposable Income Under § 1325(b)(2).** Subtract Line 57 from Line 53 and enter the result.	$

Part VI: ADDITIONAL EXPENSE CLAIMS

59 **Other Expenses.** List and describe any monthly expenses, not otherwise stated in this form, that are required for the health and welfare of you and your family and that you contend should be an additional deduction from your current monthly income under § 707(b)(2)(A)(ii)(I). If necessary, list additional sources on a separate page. All figures should reflect your average monthly expense for each item. Total the expenses.

	Expense Description	Monthly Amount
a.		$
b.		$
c.		$
	Total: Add Lines a, b, and c	$

Part VII: VERIFICATION

60 I declare under penalty of perjury that the information provided in this statement is true and correct. *(If this is a joint case, both debtors must sign.)*

Date: _____ Signature: _____
(Debtor)

Date: _____ Signature: _____
(Joint Debtor, if any)

Official Form 1 (04/07)

United States Bankruptcy Court
_____ DISTRICT OF _____

Voluntary Petition

Name of Debtor (if individual, enter Last, First, Middle):	Name of Joint Debtor (Spouse) (Last, First, Middle):
All Other Names used by the Debtor in the last 8 years (include married, maiden, and trade names):	All Other Names used by the Joint Debtor in the last 8 years (include married, maiden, and trade names):
Last four digits of Soc. Sec./Complete EIN or other Tax I.D. No. (if more than one, state all):	Last four digits of Soc. Sec./Complete EIN or other Tax I.D. No. (if more than one, state all):
Street Address of Debtor (No. and Street, City, and State): ZIP CODE	Street Address of Joint Debtor (No. and Street, City, and State): ZIP CODE
County of Residence or of the Principal Place of Business:	County of Residence or of the Principal Place of Business:
Mailing Address of Debtor (if different from street address): ZIP CODE	Mailing Address of Joint Debtor (if different from street address): ZIP CODE
Location of Principal Assets of Business Debtor (if different from street address above): ZIP CODE	

Type of Debtor
(Form of Organization)
(Check **one** box.)

- ☐ Individual (includes Joint Debtors)
  See Exhibit D on page 2 of this form.
- ☐ Corporation (includes LLC and LLP)
- ☐ Partnership
- ☐ Other (If debtor is not one of the above entities, check this box and state type of entity below.)

Nature of Business
(Check **one** box.)

- ☐ Health Care Business
- ☐ Single Asset Real Estate as defined in 11 U.S.C. § 101(51B)
- ☐ Railroad
- ☐ Stockbroker
- ☐ Commodity Broker
- ☐ Clearing Bank
- ☐ Other

Tax-Exempt Entity
(Check box, if applicable.)

- ☐ Debtor is a tax-exempt organization under Title 26 of the United States Code (the Internal Revenue Code).

Chapter of Bankruptcy Code Under Which the Petition is Filed (Check **one** box.)

- ☐ Chapter 7
- ☐ Chapter 9
- ☐ Chapter 11
- ☐ Chapter 12
- ☐ Chapter 13
- ☐ Chapter 15 Petition for Recognition of a Foreign Main Proceeding
- ☐ Chapter 15 Petition for Recognition of a Foreign Nonmain Proceeding

Nature of Debts
(Check one box.)

- ☐ Debts are primarily consumer debts, defined in 11 U.S.C. § 101(8) as "incurred by an individual primarily for a personal, family, or household purpose."
- ☐ Debts are primarily business debts.

Filing Fee (Check one box.)

- ☐ Full Filing Fee attached.
- ☐ Filing Fee to be paid in installments (applicable to individuals only). Must attach signed application for the court's consideration certifying that the debtor is unable to pay fee except in installments. Rule 1006(b). See Official Form 3A.
- ☐ Filing Fee waiver requested (applicable to chapter 7 individuals only). Must attach signed application for the court's consideration. See Official Form 3B.

Chapter 11 Debtors

Check one box:
- ☐ Debtor is a small business debtor as defined in 11 U.S.C. § 101(51D).
- ☐ Debtor is not a small business debtor as defined in 11 U.S.C. § 101(51D).

Check if:
- ☐ Debtor's aggregate noncontingent liquidated debts (excluding debts owed to insiders or affiliates) are less than $2,190,000.

Check all applicable boxes:
- ☐ A plan is being filed with this petition.
- ☐ Acceptances of the plan were solicited prepetition from one or more classes of creditors, in accordance with 11 U.S.C. § 1126(b).

Statistical/Administrative Information

- ☐ Debtor estimates that funds will be available for distribution to unsecured creditors.
- ☐ Debtor estimates that, after any exempt property is excluded and administrative expenses paid, there will be no funds available for distribution to unsecured creditors.

Estimated Number of Creditors

1-49	50-99	100-199	200-999	1,000-5,000	5,001-10,000	10,001-25,000	25,001-50,000	50,001-100,000	Over 100,000
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Estimated Assets

☐ $0 to $10,000 ☐ $10,000 to $100,000 ☐ $100,000 to $1 million ☐ $1 million to $100 million ☐ More than $100 million

Estimated Liabilities

☐ $0 to $50,000 ☐ $50,000 to $100,000 ☐ $100,000 to $1 million ☐ $1 million to $100 million ☐ More than $100 million

THIS SPACE IS FOR COURT USE ONLY

Voluntary Petition *(This page must be completed and filed in every case.)*	Name of Debtor(s):	
All Prior Bankruptcy Cases Filed Within Last 8 Years (If more than two, attach additional sheet.)		
Location Where Filed:	Case Number:	Date Filed:
Location Where Filed:	Case Number:	Date Filed:
Pending Bankruptcy Case Filed by any Spouse, Partner, or Affiliate of this Debtor (If more than one, attach additional sheet.)		
Name of Debtor:	Case Number:	Date Filed:
District:	Relationship:	Judge:

Exhibit A

(To be completed if debtor is required to file periodic reports (e.g., forms 10K and 10Q) with the Securities and Exchange Commission pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 and is requesting relief under chapter 11.)

☐ Exhibit A is attached and made a part of this petition.

Exhibit B

(To be completed if debtor is an individual whose debts are primarily consumer debts.)

I, the attorney for the petitioner named in the foregoing petition, declare that I have informed the petitioner that [he or she] may proceed under chapter 7, 11, 12, or 13 of title 11, United States Code, and have explained the relief available under each such chapter. I further certify that I have delivered to the debtor the notice required by 11 U.S.C. § 342(b).

X _____
Signature of Attorney for Debtor(s) (Date)

Exhibit C

Does the debtor own or have possession of any property that poses or is alleged to pose a threat of imminent and identifiable harm to public health or safety?

☐ Yes, and Exhibit C is attached and made a part of this petition.

☐ No.

Exhibit D

(To be completed by every individual debtor. If a joint petition is filed, each spouse must complete and attach a separate Exhibit D.)

☐ Exhibit D completed and signed by the debtor is attached and made a part of this petition.

If this is a joint petition:

☐ Exhibit D also completed and signed by the joint debtor is attached and made a part of this petition.

Information Regarding the Debtor - Venue
(Check any applicable box.)

☐ Debtor has been domiciled or has had a residence, principal place of business, or principal assets in this District for 180 days immediately preceding the date of this petition or for a longer part of such 180 days than in any other District.

☐ There is a bankruptcy case concerning debtor's affiliate, general partner, or partnership pending in this District.

☐ Debtor is a debtor in a foreign proceeding and has its principal place of business or principal assets in the United States in this District, or has no principal place of business or assets in the United States but is a defendant in an action or proceeding [in a federal or state court] in this District, or the interests of the parties will be served in regard to the relief sought in this District.

Statement by a Debtor Who Resides as a Tenant of Residential Property
(Check all applicable boxes.)

☐ Landlord has a judgment against the debtor for possession of debtor's residence. (If box checked, complete the following.)

_____
(Name of landlord that obtained judgment)

_____
(Address of landlord)

☐ Debtor claims that under applicable nonbankruptcy law, there are circumstances under which the debtor would be permitted to cure the entire monetary default that gave rise to the judgment for possession, after the judgment for possession was entered, and

☐ Debtor has included with this petition the deposit with the court of any rent that would become due during the 30-day period after the filing of the petition.

Official Form 1 (04/07) — **Form B1, Page 3**

Voluntary Petition
(This page must be completed and filed in every case.)

Name of Debtor(s):

Signatures

Signature(s) of Debtor(s) (Individual/Joint)

I declare under penalty of perjury that the information provided in this petition is true and correct.
[If petitioner is an individual whose debts are primarily consumer debts and has chosen to file under chapter 7] I am aware that I may proceed under chapter 7, 11, 12 or 13 of title 11, United States Code, understand the relief available under each such chapter, and choose to proceed under chapter 7.
[If no attorney represents me and no bankruptcy petition preparer signs the petition] I have obtained and read the notice required by 11 U.S.C. § 342(b).

I request relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X _____
Signature of Debtor

X _____
Signature of Joint Debtor

_____
Telephone Number (if not represented by attorney)

_____
Date

Signature of Attorney

X _____
Signature of Attorney for Debtor(s)

_____
Printed Name of Attorney for Debtor(s)

_____
Firm Name

_____
Address

_____

_____

_____
Telephone Number

_____
Date

Signature of Debtor (Corporation/Partnership)

I declare under penalty of perjury that the information provided in this petition is true and correct, and that I have been authorized to file this petition on behalf of the debtor.

The debtor requests the relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X _____
Signature of Authorized Individual

_____
Printed Name of Authorized Individual

_____
Title of Authorized Individual

_____
Date

Signature of a Foreign Representative

I declare under penalty of perjury that the information provided in this petition is true and correct, that I am the foreign representative of a debtor in a foreign proceeding, and that I am authorized to file this petition.

(Check only **one** box.)

☐ I request relief in accordance with chapter 15 of title 11, United States Code. Certified copies of the documents required by 11 U.S.C. § 1515 are attached.

☐ Pursuant to 11 U.S.C. § 1511, I request relief in accordance with the chapter of title 11 specified in this petition. A certified copy of the order granting recognition of the foreign main proceeding is attached.

X _____
(Signature of Foreign Representative)

_____
(Printed Name of Foreign Representative)

_____
Date

Signature of Non-Attorney Bankruptcy Petition Preparer

I declare under penalty of perjury that: (1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110; (2) I prepared this document for compensation and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h), and 342(b); and, (3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110(h) setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required in that section. Official Form 19B is attached.

_____
Printed Name and title, if any, of Bankruptcy Petition Preparer

_____
Social Security number (If the bankruptcy petition preparer is not an individual, state the Social Security number of the officer, principal, responsible person or partner of the bankruptcy petition preparer.) (Required by 11 U.S.C. § 110.)

_____
Address

_____

X _____

_____
Date

Signature of bankruptcy petition preparer or officer, principal, responsible person, or partner whose Social Security number is provided above.

Names and Social Security numbers of all other individuals who prepared or assisted in preparing this document unless the bankruptcy petition preparer is not an individual.

If more than one person prepared this document, attach additional sheets conforming to the appropriate official form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both. 11 U.S.C. § 110; 18 U.S.C. § 156.

Form 4
(10/05)

United States Bankruptcy Court

_____ District Of _____

In re _____, Case No. _____
Debtor

Chapter _____

LIST OF CREDITORS HOLDING 20 LARGEST UNSECURED CLAIMS

Following is the list of the debtor's creditors holding the 20 largest unsecured claims. The list is prepared in accordance with Fed. R. Bankr. P. 1007(d) for filing in this chapter 11 [*or* chapter 9] case. The list does not include (1) persons who come within the definition of "insider" set forth in 11 U.S.C. § 101, or (2) secured creditors unless the value of the collateral is such that the unsecured deficiency places the creditor among the holders of the 20 largest unsecured claims. If a minor child is one of the creditors holding the 20 largest unsecured claims, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112: Fed. R. Bankr. P. 1007(m).

(1)	(2)	(3)	(4)	(5)
Name of creditor and complete mailing address including zip code	*Name, telephone number and complete mailing address, including zip code, of employee, agent, or department of creditor familiar with claim who may be contacted*	*Nature of claim (trade debt, bank loan, government contract, etc.)*	*Indicate if claim is contingent, unliquidated, disputed or subject to setoff*	*Amount of claim [if secured also state value of security]*

Date: _____

_____
Debtor

[Declaration as in Form 2]

Official Form 6 - Summary (10/06)

United States Bankruptcy Court

_____ District Of _____

In re _____, Case No. _____

Debtor

Chapter _____

SUMMARY OF SCHEDULES

Indicate as to each schedule whether that schedule is attached and state the number of pages in each. Report the totals from Schedules A, B, D, E, F, I, and J in the boxes provided. Add the amounts from Schedules A and B to determine the total amount of the debtor's assets. Add the amounts of all claims from Schedules D, E, and F to determine the total amount of the debtor's liabilities. Individual debtors also must complete the "Statistical Summary of Certain Liabilities and Related Data" if they file a case under chapter 7, 11, or 13.

NAME OF SCHEDULE	ATTACHED (YES/NO)	NO. OF SHEETS	ASSETS	LIABILITIES	OTHER
A - Real Property			$		
B - Personal Property			$		
C - Property Claimed as Exempt					
D - Creditors Holding Secured Claims				$	
E - Creditors Holding Unsecured Priority Claims (Total of Claims on Schedule E)				$	
F - Creditors Holding Unsecured Nonpriority Claims				$	
G - Executory Contracts and Unexpired Leases					
H - Codebtors					
I - Current Income of Individual Debtor(s)					$
J - Current Expenditures of Individual Debtors(s)					$
TOTAL			$	$	

Official Form 6 - Statistical Summary (10/06)

United States Bankruptcy Court

_____ District Of _____

In re _____, Case No. _____

Debtor

Chapter _____

STATISTICAL SUMMARY OF CERTAIN LIABILITIES AND RELATED DATA (28 U.S.C. § 159)

If you are an individual debtor whose debts are primarily consumer debts, as defined in § 101(8) of the Bankruptcy Code (11 U.S.C. § 101(8)), filing a case under chapter 7, 11 or 13, you must report all information requested below.

☐ Check this box if you are an individual debtor whose debts are NOT primarily consumer debts. You are not required to report any information here.

This information is for statistical purposes only under 28 U.S.C. § 159.

Summarize the following types of liabilities, as reported in the Schedules, and total them.

Type of Liability	**Amount**
Domestic Support Obligations (from Schedule E)	$
Taxes and Certain Other Debts Owed to Governmental Units (from Schedule E) (whether disputed or undisputed)	$
Claims for Death or Personal Injury While Debtor Was Intoxicated (from Schedule E)	$
Student Loan Obligations (from Schedule F)	$
Domestic Support, Separation Agreement, and Divorce Decree Obligations Not Reported on Schedule E	$
Obligations to Pension or Profit-Sharing, and Other Similar Obligations (from Schedule F)	$
TOTAL	$

State the following:

Average Income (from Schedule I, Line 16)	$
Average Expenses (from Schedule J, Line 18)	$
Current Monthly Income (from Form 22A Line 12; **OR**, Form 22B Line 11; **OR**, Form 22C Line 20)	$

State the following:

1. Total from Schedule D, "UNSECURED PORTION, IF ANY" column		$
2. Total from Schedule E, "AMOUNT ENTITLED TO PRIORITY" column.	$	
3. Total from Schedule E, "AMOUNT NOT ENTITLED TO PRIORITY, IF ANY" column		$
4. Total from Schedule F		$
5. Total of non-priority unsecured debt (sum of 1, 3, and 4)		$

Form B6A
(10/05)

In re _____, Case No. _____
Debtor (If known)

SCHEDULE A - REAL PROPERTY

Except as directed below, list all real property in which the debtor has any legal, equitable, or future interest, including all property owned as a co-tenant, community property, or in which the debtor has a life estate. Include any property in which the debtor holds rights and powers exercisable for the debtor's own benefit. If the debtor is married, state whether husband, wife, or both own the property by placing an "H," "W," "J," or "C" in the column labeled "Husband, Wife, Joint, or Community." If the debtor holds no interest in real property, write "None" under "Description and Location of Property."

Do not include interests in executory contracts and unexpired leases on this schedule. List them in Schedule G - Executory Contracts and Unexpired Leases.

If an entity claims to have a lien or hold a secured interest in any property, state the amount of the secured claim. See Schedule D. If no entity claims to hold a secured interest in the property, write "None" in the column labeled "Amount of Secured Claim."

If the debtor is an individual or if a joint petition is filed, state the amount of any exemption claimed in the property only in Schedule C - Property Claimed as Exempt.

DESCRIPTION AND LOCATION OF PROPERTY	NATURE OF DEBTOR'S INTEREST IN PROPERTY	HUSBAND, WIFE, JOINT, OR COMMUNITY	CURRENT VALUE OF DEBTOR'S INTEREST IN PROPERTY, WITHOUT DEDUCTING ANY SECURED CLAIM OR EXEMPTION	AMOUNT OF SECURED CLAIM
		Total ➤		

(Report also on Summary of Schedules.)

Form B6B
(10/05)

In re _____, **Case No.** _____
Debtor **(If known)**

SCHEDULE B - PERSONAL PROPERTY

Except as directed below, list all personal property of the debtor of whatever kind. If the debtor has no property in one or more of the categories, place an "x" in the appropriate position in the column labeled "None." If additional space is needed in any category, attach a separate sheet properly identified with the case name, case number, and the number of the category. If the debtor is married, state whether husband, wife, or both own the property by placing an "H," "W," "J," or "C" in the column labeled "Husband, Wife, Joint, or Community." If the debtor is an individual or a joint petition is filed, state the amount of any exemptions claimed only in Schedule C - Property Claimed as Exempt.

Do not list interests in executory contracts and unexpired leases on this schedule. List them in Schedule G - Executory Contracts and Unexpired Leases.

If the property is being held for the debtor by someone else, state that person's name and address under "Description and Location of Property." In providing the information requested in this schedule, do not include the name or address of a minor child. Simply state "a minor child."

TYPE OF PROPERTY	NONE	DESCRIPTION AND LOCATION OF PROPERTY	HUSBAND, WIFE, JOINT, OR COMMUNITY	CURRENT VALUE OF DEBTOR'S INTEREST IN PROPERTY, WITHOUT DEDUCTING ANY SECURED CLAIM OR EXEMPTION
1. Cash on hand.				
2. Checking, savings or other financial accounts, certificates of deposit, or shares in banks, savings and loan, thrift, building and loan, and homestead associations, or credit unions, brokerage houses, or cooperatives.				
3. Security deposits with public utilities, telephone companies, landlords, and others.				
4. Household goods and furnishings, including audio, video, and computer equipment.				
5. Books; pictures and other art objects; antiques; stamp, coin, record, tape, compact disc, and other collections or collectibles.				
6. Wearing apparel.				
7. Furs and jewelry.				
8. Firearms and sports, photographic, and other hobby equipment.				
9. Interests in insurance policies. Name insurance company of each policy and itemize surrender or refund value of each.				
10. Annuities. Itemize and name each issuer.				
11. Interests in an education IRA as defined in 26 U.S.C. § 530(b)(1) or under a qualified State tuition plan as defined in 26 U.S.C. § 529(b)(1). Give particulars. (File separately the record(s) of any such interest(s). 11 U.S.C. § 521(c); Rule 1007(b)).				

Form B6B-Cont.
(10/05)

In re _____, Debtor

Case No. _____ (If known)

SCHEDULE B - PERSONAL PROPERTY
(Continuation Sheet)

TYPE OF PROPERTY	NONE	DESCRIPTION AND LOCATION OF PROPERTY	HUSBAND, WIFE, JOINT, OR COMMUNITY	CURRENT VALUE OF DEBTOR'S INTEREST IN PROPERTY, WITHOUT DEDUCTING ANY SECURED CLAIM OR EXEMPTION
12. Interests in IRA, ERISA, Keogh, or other pension or profit sharing plans. Give particulars.				
13. Stock and interests in incorporated and unincorporated businesses. Itemize.				
14. Interests in partnerships or joint ventures. Itemize.				
15. Government and corporate bonds and other negotiable and non-negotiable instruments.				
16. Accounts receivable.				
17. Alimony, maintenance, support, and property settlements to which the debtor is or may be entitled. Give particulars.				
18. Other liquidated debts owed to debtor including tax refunds. Give particulars.				
19. Equitable or future interests, life estates, and rights or powers exercisable for the benefit of the debtor other than those listed in Schedule A – Real Property.				
20. Contingent and noncontingent interests in estate of a decedent, death benefit plan, life insurance policy, or trust.				
21. Other contingent and unliquidated claims of every nature, including tax refunds, counterclaims of the debtor, and rights to setoff claims. Give estimated value of each.				

Form B6B-cont.
(10/05)

In re _____, Case No. _____
Debtor (If known)

SCHEDULE B -PERSONAL PROPERTY

(Continuation Sheet)

TYPE OF PROPERTY	NONE	DESCRIPTION AND LOCATION OF PROPERTY	HUSBAND, WIFE, JOINT, OR COMMUNITY	CURRENT VALUE OF DEBTOR'S INTEREST IN PROPERTY, WITH-OUT DEDUCTING ANY SECURED CLAIM OR EXEMPTION
22. Patents, copyrights, and other intellectual property. Give particulars.				
23. Licenses, franchises, and other general intangibles. Give particulars.				
24. Customer lists or other compilations containing personally identifiable information (as defined in 11 U.S.C. § 101(41A)) provided to the debtor by individuals in connection with obtaining a product or service from the debtor primarily for personal, family, or household purposes.				
25. Automobiles, trucks, trailers, and other vehicles and accessories.				
26. Boats, motors, and accessories.				
27. Aircraft and accessories.				
28. Office equipment, furnishings, and supplies.				
29. Machinery, fixtures, equipment, and supplies used in business.				
30. Inventory.				
31. Animals.				
32. Crops - growing or harvested. Give particulars.				
33. Farming equipment and implements.				
34. Farm supplies, chemicals, and feed.				
35. Other personal property of any kind not already listed. Itemize.				
		_____continuation sheets attached Total ➤ (Include amounts from any continuation sheets attached. Report total also on Summary of Schedules.)		$

Official Form 6C (04/07)

In re _____, **Debtor**

Case No._____ **(if known)**

SCHEDULE C - PROPERTY CLAIMED AS EXEMPT

Debtor claims the exemptions to which debtor is entitled under:
(Check one box)
☐ 11 U.S.C. § 522(b)(2)
☐ 11 U.S.C. § 522(b)(3)

☐ Check if debtor claims a homestead exemption that exceeds $136,875

DESCRIPTION OF PROPERTY	SPECIFY LAW PROVIDING EACH EXEMPTION	VALUE OF CLAIMED EXEMPTION	CURRENT VALUE OF PROPERTY WITHOUT DEDUCTING EXEMPTION

Official Form 6D (10/06)

In re _____, **Case No.** _____
Debtor **(if known)**

SCHEDULE D - CREDITORS HOLDING SECURED CLAIMS

State the name, mailing address, including zip code, and last four digits of any account number of all entities holding claims secured by property of the debtor as of the date of filing of the petition. The complete account number of any account the debtor has with the creditor is useful to the trustee and the creditor and may be provided if the debtor chooses to do so. List creditors holding all types of secured interests such as judgment liens, garnishments, statutory liens, mortgages, deeds of trust, and other security interests.

List creditors in alphabetical order to the extent practicable. If a minor child is a creditor, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112. If "a minor child" is stated, also include the name, address, and legal relationship to the minor child of a person described in Fed. R. Bankr. P. 1007(m). If all secured creditors will not fit on this page, use the continuation sheet provided.

If any entity other than a spouse in a joint case may be jointly liable on a claim, place an "X" in the column labeled "Codebtor," include the entity on the appropriate schedule of creditors, and complete Schedule H – Codebtors. If a joint petition is filed, state whether the husband, wife, both of them, or the marital community may be liable on each claim by placing an "H," "W," "J," or "C" in the column labeled "Husband, Wife, Joint, or Community."

If the claim is contingent, place an "X" in the column labeled "Contingent." If the claim is unliquidated, place an "X" in the column labeled "Unliquidated." If the claim is disputed, place an "X" in the column labeled "Disputed." (You may need to place an "X" in more than one of these three columns.)

Total the columns labeled "Amount of Claim Without Deducting Value of Collateral" and "Unsecured Portion, if Any" in the boxes labeled "Total(s)" on the last sheet of the completed schedule. Report the total from the column labeled "Amount of Claim Without Deducting Value of Collateral" also on the Summary of Schedules and, if the debtor is an individual with primarily consumer debts, report the total from the column labeled "Unsecured Portion, if Any" on the Statistical Summary of Certain Liabilities and Related Data.

☐ Check this box if debtor has no creditors holding secured claims to report on this Schedule D.

CREDITOR'S NAME AND MAILING ADDRESS INCLUDING ZIP CODE AND AN ACCOUNT NUMBER (*See Instructions Above.*)	CODEBTOR	HUSBAND, WIFE, JOINT, OR COMMUNITY	DATE CLAIM WAS INCURRED, NATURE OF LIEN, AND DESCRIPTION AND VALUE OF PROPERTY SUBJECT TO LIEN	CONTINGENT	UNLIQUIDATED	DISPUTED	AMOUNT OF CLAIM WITHOUT DEDUCTING VALUE OF COLLATERAL	UNSECURED PORTION, IF ANY
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
____continuation sheets attached			Subtotal ► (Total of this page)				$	$
			Total ► (Use only on last page)				$ (Report also on Summary of Schedules.)	$ (If applicable, report also on Statistical Summary of Certain Liabilities and Related Data.)

Official Form 6D (10/06) – Cont.
In re _____, **Case No.** _____
Debtor **(if known)**

SCHEDULE D - CREDITORS HOLDING SECURED CLAIMS
(Continuation Sheet)

CREDITOR'S NAME AND MAILING ADDRESS INCLUDING ZIP CODE AND AN ACCOUNT NUMBER (*See Instructions Above.*)	CODEBTOR	HUSBAND, WIFE, JOINT, OR COMMUNITY	DATE CLAIM WAS INCURRED, NATURE OF LIEN, AND DESCRIPTION AND VALUE OF PROPERTY SUBJECT TO LIEN	CONTINGENT	UNLIQUIDATED	DISPUTED	AMOUNT OF CLAIM WITHOUT DEDUCTING VALUE OF COLLATERAL	UNSECURED PORTION, IF ANY
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
ACCOUNT NO.			VALUE $					
Sheet no.___of___continuation sheets attached to Schedule of Creditors Holding Secured Claims			Subtotal (s)▶ (Total(s) of this page)				$	$
			Total(s) ▶ (Use only on last page)				$ (Report also on Summary of Schedules.)	$ (If applicable, report also on Statistical Summary of Certain Liabilities and Related Data.)

Official Form 6E (04/07)

In re _____, **Case No.**_____
Debtor **(if known)**

SCHEDULE E - CREDITORS HOLDING UNSECURED PRIORITY CLAIMS

A complete list of claims entitled to priority, listed separately by type of priority, is to be set forth on the sheets provided. Only holders of unsecured claims entitled to priority should be listed in this schedule. In the boxes provided on the attached sheets, state the name, mailing address, including zip code, and last four digits of the account number, if any, of all entities holding priority claims against the debtor or the property of the debtor, as of the date of the filing of the petition. Use a separate continuation sheet for each type of priority and label each with the type of priority.

The complete account number of any account the debtor has with the creditor is useful to the trustee and the creditor and may be provided if the debtor chooses to do so. If a minor child is a creditor, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112. If "a minor child" is stated, also include the name, address, and legal relationship to the minor child of a person described in Fed. R. Bankr. P. 1007(m).

If any entity other than a spouse in a joint case may be jointly liable on a claim, place an "X" in the column labeled "Codebtor," include the entity on the appropriate schedule of creditors, and complete Schedule H-Codebtors. If a joint petition is filed, state whether the husband, wife, both of them, or the marital community may be liable on each claim by placing an "H," "W," "J," or "C" in the column labeled "Husband, Wife, Joint, or Community." If the claim is contingent, place an "X" in the column labeled "Contingent." If the claim is unliquidated, place an "X" in the column labeled "Unliquidated." If the claim is disputed, place an "X" in the column labeled "Disputed." (You may need to place an "X" in more than one of these three columns.)

Report the total of claims listed on each sheet in the box labeled "Subtotals" on each sheet. Report the total of all claims listed on this Schedule E in the box labeled "Total" on the last sheet of the completed schedule. Report this total also on the Summary of Schedules.

Report the total of amounts entitled to priority listed on each sheet in the box labeled "Subtotals" on each sheet. Report the total of all amounts entitled to priority listed on this Schedule E in the box labeled "Totals" on the last sheet of the completed schedule. Individual debtors with primarily consumer debts who file a case under chapter 7 or 13 report this total also on the Statistical Summary of Certain Liabilities and Related Data.

Report the total of amounts not entitled to priority listed on each sheet in the box labeled "Subtotals" on each sheet. Report the total of all amounts not entitled to priority listed on this Schedule E in the box labeled "Totals" on the last sheet of the completed schedule. Individual debtors with primarily consumer debts who file a case under chapter 7 report this total also on the Statistical Summary of Certain Liabilities and Related Data.

☐ Check this box if debtor has no creditors holding unsecured priority claims to report on this Schedule E.

TYPES OF PRIORITY CLAIMS (Check the appropriate box(es) below if claims in that category are listed on the attached sheets)

☐ **Domestic Support Obligations**

Claims for domestic support that are owed to or recoverable by a spouse, former spouse, or child of the debtor, or the parent, legal guardian, or responsible relative of such a child, or a governmental unit to whom such a domestic support claim has been assigned to the extent provided in 11 U.S.C. § 507(a)(1).

☐ **Extensions of credit in an involuntary case**

Claims arising in the ordinary course of the debtor's business or financial affairs after the commencement of the case but before the earlier of the appointment of a trustee or the order for relief. 11 U.S.C. § 507(a)(3).

☐ **Wages, salaries, and commissions**

Wages, salaries, and commissions, including vacation, severance, and sick leave pay owing to employees and commissions owing to qualifying independent sales representatives up to $10,950* per person earned within 180 days immediately preceding the filing of the original petition, or the cessation of business, whichever occurred first, to the extent provided in 11 U.S.C. § 507(a)(4).

☐ **Contributions to employee benefit plans**

Money owed to employee benefit plans for services rendered within 180 days immediately preceding the filing of the original petition, or the cessation of business, whichever occurred first, to the extent provided in 11 U.S.C. § 507(a)(5).

Official Form 6E (04/07) - Cont.

In re _____ , **Case No.**_____
Debtor **(if known)**

☐ **Certain farmers and fishermen**

Claims of certain farmers and fishermen, up to $5,400* per farmer or fisherman, against the debtor, as provided in 11 U.S.C. § 507(a)(6).

☐ **Deposits by individuals**

Claims of individuals up to $2,425* for deposits for the purchase, lease, or rental of property or services for personal, family, or household use, that were not delivered or provided. 11 U.S.C. § 507(a)(7).

☐ **Taxes and Certain Other Debts Owed to Governmental Units**

Taxes, customs duties, and penalties owing to federal, state, and local governmental units as set forth in 11 U.S.C. § 507(a)(8).

☐ **Commitments to Maintain the Capital of an Insured Depository Institution**

Claims based on commitments to the FDIC, RTC, Director of the Office of Thrift Supervision, Comptroller of the Currency, or Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution. 11 U.S.C. § 507 (a)(9).

☐ **Claims for Death or Personal Injury While Debtor Was Intoxicated**

Claims for death or personal injury resulting from the operation of a motor vehicle or vessel while the debtor was intoxicated from using alcohol, a drug, or another substance. 11 U.S.C. § 507(a)(10).

* Amounts are subject to adjustment on April 1, 2010, and every three years thereafter with respect to cases commenced on or after the date of adjustment.

____ **continuation sheets attached**

Official Form 6E (04/07) - Cont.

In re _____, **Case No.** _____
Debtor **(If known)**

SCHEDULE E - CREDITORS HOLDING UNSECURED PRIORITY CLAIMS

(Continuation Sheet)

Type of Priority for Claims Listed on This Sheet

CREDITOR'S NAME, MAILING ADDRESS INCLUDING ZIP CODE, AND ACCOUNT NUMBER (*See instructions above.*)	CODEBTOR	HUSBAND, WIFE, JOINT, OR COMMUNITY	DATE CLAIM WAS INCURRED AND CONSIDERATION FOR CLAIM	CONTINGENT	UNLIQUIDATED	DISPUTED	AMOUNT OF CLAIM	AMOUNT ENTITLED TO PRIORITY	AMOUNT NOT ENTITLED TO PRIORITY, IF ANY
Account No.									
Account No.									
Account No.									
Account No.									
Sheet no. ___ of ___ continuation sheets attached to Schedule of Creditors Holding Priority Claims						Subtotals➤ (Totals of this page)	$	$	
						Total➤ (Use only on last page of the completed Schedule E. Report also on the Summary of Schedules.)	$		
						Totals➤ (Use only on last page of the completed Schedule E. If applicable, report also on the Statistical Summary of Certain Liabilities and Related Data.)		$	$

Official Form 6F (10/06)

In re _____, Debtor Case No. _____ (if known)

SCHEDULE F - CREDITORS HOLDING UNSECURED NONPRIORITY CLAIMS

State the name, mailing address, including zip code, and last four digits of any account number, of all entities holding unsecured claims without priority against the debtor or the property of the debtor, as of the date of filing of the petition. The complete account number of any account the debtor has with the creditor is useful to the trustee and the creditor and may be provided if the debtor chooses to do so. If a minor child is a creditor, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112. If "a minor child" is stated, also include the name, address, and legal relationship to the minor child of a person described in Fed. R. Bankr. P. 1007(m). Do not include claims listed in Schedules D and E. If all creditors will not fit on this page, use the continuation sheet provided.

If any entity other than a spouse in a joint case may be jointly liable on a claim, place an "X" in the column labeled "Codebtor," include the entity on the appropriate schedule of creditors, and complete Schedule H - Codebtors. If a joint petition is filed, state whether the husband, wife, both of them, or the marital community may be liable on each claim by placing an "H," "W," "J," or "C" in the column labeled "Husband, Wife, Joint, or Community."

If the claim is contingent, place an "X" in the column labeled "Contingent." If the claim is unliquidated, place an "X" in the column labeled "Unliquidated." If the claim is disputed, place an "X" in the column labeled "Disputed." (You may need to place an "X" in more than one of these three columns.)

Report the total of all claims listed on this schedule in the box labeled "Total" on the last sheet of the completed schedule. Report this total also on the Summary of Schedules and, if the debtor is an individual with primarily consumer debts filing a case under chapter 7, report this total also on the Statistical Summary of Certain Liabilities and Related Data..

☐ Check this box if debtor has no creditors holding unsecured claims to report on this Schedule F.

CREDITOR'S NAME, MAILING ADDRESS INCLUDING ZIP CODE, AND ACCOUNT NUMBER *(See instructions above.)*	CODEBTOR	HUSBAND, WIFE, JOINT, OR COMMUNITY	DATE CLAIM WAS INCURRED AND CONSIDERATION FOR CLAIM. IF CLAIM IS SUBJECT TO SETOFF, SO STATE.	CONTINGENT	UNLIQUIDATED	DISPUTED	AMOUNT OF CLAIM
ACCOUNT NO.							
ACCOUNT NO.							
ACCOUNT NO.							
ACCOUNT NO.							
						Subtotal➤	$
						Total➤ (Use only on last page of the completed Schedule F.) (Report also on Summary of Schedules and, if applicable, on the Statistical Summary of Certain Liabilities and Related Data.)	$

_____continuation sheets attached

Official Form 6F (10/06) - Cont.

In re _____, **Case No.** _____
Debtor **(if known)**

SCHEDULE F - CREDITORS HOLDING UNSECURED NONPRIORITY CLAIMS

(Continuation Sheet)

CREDITOR'S NAME, MAILING ADDRESS INCLUDING ZIP CODE, AND ACCOUNT NUMBER (See instructions above.)	CODEBTOR	HUSBAND, WIFE, JOINT, OR COMMUNITY	DATE CLAIM WAS INCURRED AND CONSIDERATION FOR CLAIM. IF CLAIM IS SUBJECT TO SETOFF, SO STATE.	CONTINGENT	UNLIQUIDATED	DISPUTED	AMOUNT OF CLAIM
ACCOUNT NO.							
ACCOUNT NO.							
ACCOUNT NO.							
ACCOUNT NO.							
ACCOUNT NO.							

Sheet no.___of___continuation sheets attached to Schedule of Creditors Holding Unsecured Nonpriority Claims

Subtotal➤ $

Total➤ $
(Use only on last page of the completed Schedule F.)
(Report also on Summary of Schedules and, if applicable on the Statistical Summary of Certain Liabilities and Related Data.)

Form B6G
(10/05)

In re _____, Case No._____
Debtor (if known)

SCHEDULE G - EXECUTORY CONTRACTS AND UNEXPIRED LEASES

Describe all executory contracts of any nature and all unexpired leases of real or personal property. Include any timeshare interests. State nature of debtor's interest in contract, i.e., "Purchaser," "Agent," etc. State whether debtor is the lessor or lessee of a lease. Provide the names and complete mailing addresses of all other parties to each lease or contract described. If a minor child is a party to one of the leases or contracts, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112; Fed.R. Bankr. P. 1007(m).

☐ Check this box if debtor has no executory contracts or unexpired leases.

NAME AND MAILING ADDRESS, INCLUDING ZIP CODE, OF OTHER PARTIES TO LEASE OR CONTRACT.	DESCRIPTION OF CONTRACT OR LEASE AND NATURE OF DEBTOR'S INTEREST. STATE WHETHER LEASE IS FOR NONRESIDENTIAL REAL PROPERTY. STATE CONTRACT NUMBER OF ANY GOVERNMENT CONTRACT.

Form B6H
(10/05)

In re _____, Debtor

Case No. _____ (if known)

SCHEDULE H - CODEBTORS

Provide the information requested concerning any person or entity, other than a spouse in a joint case, that is also liable on any debts listed by debtor in the schedules of creditors. Include all guarantors and co-signers. If the debtor resides or resided in a community property state, commonwealth, or territory (including Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin) within the eight year period immediately preceding the commencement of the case, identify the name of the debtor's spouse and of any former spouse who resides or resided with the debtor in the community property state, commonwealth, or territory. Include all names used by the nondebtor spouse during the eight years immediately preceding the commencement of this case. If a minor child is a codebtor or a creditor, indicate that by stating "a minor child" and do not disclose the child's name. See 11 U.S.C. § 112; Fed. Bankr. P. 1007(m).

☐ Check this box if debtor has no codebtors.

NAME AND ADDRESS OF CODEBTOR	NAME AND ADDRESS OF CREDITOR

Official Form 6I (10/06)

In re _____ , **Case No.** _____
Debtor **(if known)**

SCHEDULE I - CURRENT INCOME OF INDIVIDUAL DEBTOR(S)

The column labeled "Spouse" must be completed in all cases filed by joint debtors and by every married debtor, whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed. Do not state the name of any minor child.

Debtor's Marital Status:	DEPENDENTS OF DEBTOR AND SPOUSE	
	RELATIONSHIP(S):	AGE(S):

Employment: Occupation	DEBTOR	SPOUSE
Name of Employer		
How long employed		
Address of Employer		

INCOME: (Estimate of average or projected monthly income at time case filed)	DEBTOR	SPOUSE
1. Monthly gross wages, salary, and commissions (Prorate if not paid monthly)	$_____	$_____
2. Estimate monthly overtime	$_____	$_____
3. SUBTOTAL	$_____	$_____
4. LESS PAYROLL DEDUCTIONS		
a. Payroll taxes and social security	$_____	$_____
b. Insurance	$_____	$_____
c. Union dues	$_____	$_____
d. Other (Specify): _____	$_____	$_____
5. SUBTOTAL OF PAYROLL DEDUCTIONS	$_____	$_____
6. TOTAL NET MONTHLY TAKE HOME PAY	$_____	$_____
7. Regular income from operation of business or profession or farm (Attach detailed statement)	$_____	$_____
8. Income from real property	$_____	$_____
9. Interest and dividends	$_____	$_____
10. Alimony, maintenance or support payments payable to the debtor for the debtor's use or that of dependents listed above	$_____	$_____
11. Social security or government assistance (Specify): _____	$_____	$_____
12. Pension or retirement income	$_____	$_____
13. Other monthly income (Specify): _____	$_____	$_____
14. SUBTOTAL OF LINES 7 THROUGH 13	$_____	$_____
15. AVERAGE MONTHLY INCOME (Add amounts shown on lines 6 and 14)	$_____	$_____
16. COMBINED AVERAGE MONTHLY INCOME: (Combine column totals from line 15; if there is only one debtor repeat total reported on line 15)	$_____ (Report also on Summary of Schedules and, if applicable, on Statistical Summary of Certain Liabilities and Related Data)	

17. Describe any increase or decrease in income reasonably anticipated to occur within the year following the filing of this document:

_____

_____

Official Form 6J (10/06)

In re _____, Debtor Case No. _____ (if known)

SCHEDULE J - CURRENT EXPENDITURES OF INDIVIDUAL DEBTOR(S)

Complete this schedule by estimating the average or projected monthly expenses of the debtor and the debtor's family at time case filed. Prorate any payments made bi-weekly, quarterly, semi-annually, or annually to show monthly rate.

☐ Check this box if a joint petition is filed and debtor's spouse maintains a separate household. Complete a separate schedule of expenditures labeled "Spouse."

1. Rent or home mortgage payment (include lot rented for mobile home) $ _____
   a. Are real estate taxes included? Yes _____ No _____
   b. Is property insurance included? Yes _____ No _____
2. Utilities: a. Electricity and heating fuel $ _____
   b. Water and sewer $ _____
   c. Telephone $ _____
   d. Other _____ $ _____
3. Home maintenance (repairs and upkeep) $ _____
4. Food $ _____
5. Clothing $ _____
6. Laundry and dry cleaning $ _____
7. Medical and dental expenses $ _____
8. Transportation (not including car payments) $ _____
9. Recreation, clubs and entertainment, newspapers, magazines, etc. $ _____
10. Charitable contributions $ _____
11. Insurance (not deducted from wages or included in home mortgage payments)
    a. Homeowner's or renter's $ _____
    b. Life $ _____
    c. Health $ _____
    d. Auto $ _____
    e. Other _____ $ _____
12. Taxes (not deducted from wages or included in home mortgage payments) (Specify) _____ $ _____
13. Installment payments: (In chapter 11, 12, and 13 cases, do not list payments to be included in the plan)
    a. Auto $ _____
    b. Other _____ $ _____
    c. Other _____ $ _____
14. Alimony, maintenance, and support paid to others $ _____
15. Payments for support of additional dependents not living at your home $ _____
16. Regular expenses from operation of business, profession, or farm (attach detailed statement) $ _____
17. Other _____ $ _____
18. AVERAGE MONTHLY EXPENSES (Total lines 1-17. Report also on Summary of Schedules and, if applicable, on the Statistical Summary of Certain Liabilities and Related Data.) $ _____
19. Describe any increase or decrease in expenditures reasonably anticipated to occur within the year following the filing of this document:
    _____
    _____
    _____
20. STATEMENT OF MONTHLY NET INCOME
    a. Average monthly income from Line 15 of Schedule I $ _____
    b. Average monthly expenses from Line 18 above $ _____
    c. Monthly net income (a. minus b.) $ _____

Official Form 6 - Declaration (10/06)

In re _____ , **Case No.** _____
Debtor **(if known)**

DECLARATION CONCERNING DEBTOR'S SCHEDULES

DECLARATION UNDER PENALTY OF PERJURY BY INDIVIDUAL DEBTOR

I declare under penalty of perjury that I have read the foregoing summary and schedules, consisting of ____ sheets (*total shown on summary page plus 2*), and that they are true and correct to the best of my knowledge, information, and belief.

Date _____ Signature: _____
Debtor

Date _____ Signature: _____
(Joint Debtor, if any)

[If joint case, both spouses must sign.]

DECLARATION AND SIGNATURE OF NON-ATTORNEY BANKRUPTCY PETITION PREPARER (See 11 U.S.C. § 110)

I declare under penalty of perjury that: (1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110; (2) I prepared this document for compensation and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h) and 342(b); and, (3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110(h) setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required by that section.

_____ _____
Printed or Typed Name and Title, if any, of Bankruptcy Petition Preparer — Social Security No. *(Required by 11 U.S.C. § 110.)*

If the bankruptcy petition preparer is not an individual, state the name, title (if any), address, and social security number of the officer, principal, responsible person, or partner who signs this document.

_____
_____
_____
Address

X _____ _____
Signature of Bankruptcy Petition Preparer — Date

Names and Social Security numbers of all other individuals who prepared or assisted in preparing this document, unless the bankruptcy petition preparer is not an individual:

If more than one person prepared this document, attach additional signed sheets conforming to the appropriate Official Form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both. 11 U.S.C. § 110; 18 U.S.C. § 156.

DECLARATION UNDER PENALTY OF PERJURY ON BEHALF OF A CORPORATION OR PARTNERSHIP

I, the _____ [the president or other officer or an authorized agent of the corporation or a member or an authorized agent of the partnership] of the _____ [corporation or partnership] named as debtor in this case, declare under penalty of perjury that I have read the foregoing summary and schedules, consisting of ____ sheets (*total shown on summary page plus 1*), and that they are true and correct to the best of my knowledge, information, and belief.

Date _____ Signature: _____

_____
[Print or type name of individual signing on behalf of debtor.]

[An individual signing on behalf of a partnership or corporation must indicate position or relationship to debtor.]

Penalty for making a false statement or concealing property: Fine of up to $500,000 or imprisonment for up to 5 years or both. 18 U.S.C. §§ 152 and 3571.

Official Form 7
(04/07)

UNITED STATES BANKRUPTCY COURT

_____ DISTRICT OF _____

In re: _____, Debtor Case No. _____ (if known)

STATEMENT OF FINANCIAL AFFAIRS

This statement is to be completed by every debtor. Spouses filing a joint petition may file a single statement on which the information for both spouses is combined. If the case is filed under chapter 12 or chapter 13, a married debtor must furnish information for both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed. An individual debtor engaged in business as a sole proprietor, partner, family farmer, or self-employed professional, should provide the information requested on this statement concerning all such activities as well as the individual's personal affairs. Do not include the name or address of a minor child in this statement. Indicate payments, transfers and the like to minor children by stating "a minor child." See 11 U.S.C. § 112; Fed. R. Bankr. P. 1007(m).

Questions 1 - 18 are to be completed by all debtors. Debtors that are or have been in business, as defined below, also must complete Questions 19 - 25. **If the answer to an applicable question is "None," mark the box labeled "None."** If additional space is needed for the answer to any question, use and attach a separate sheet properly identified with the case name, case number (if known), and the number of the question.

DEFINITIONS

"In business." A debtor is "in business" for the purpose of this form if the debtor is a corporation or partnership. An individual debtor is "in business" for the purpose of this form if the debtor is or has been, within six years immediately preceding the filing of this bankruptcy case, any of the following: an officer, director, managing executive, or owner of 5 percent or more of the voting or equity securities of a corporation; a partner, other than a limited partner, of a partnership; a sole proprietor or self-employed full-time or part-time. An individual debtor also may be "in business" for the purpose of this form if the debtor engages in a trade, business, or other activity, other than as an employee, to supplement income from the debtor's primary employment.

"Insider." The term "insider" includes but is not limited to: relatives of the debtor; general partners of the debtor and their relatives; corporations of which the debtor is an officer, director, or person in control; officers, directors, and any owner of 5 percent or more of the voting or equity securities of a corporate debtor and their relatives; affiliates of the debtor and insiders of such affiliates; any managing agent of the debtor. 11 U.S.C. § 101.

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1. Income from employment or operation of business

None ☐ State the gross amount of income the debtor has received from employment, trade, or profession, or from operation of the debtor's business, including part-time activities either as an employee or in independent trade or business, from the beginning of this calendar year to the date this case was commenced. State also the gross amounts received during the **two years** immediately preceding this calendar year. (A debtor that maintains, or has maintained, financial records on the basis of a fiscal rather than a calendar year may report fiscal year income. Identify the beginning and ending dates of the debtor's fiscal year.) If a joint petition is filed, state income for each spouse separately. (Married debtors filing under chapter 12 or chapter 13 must state income of both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

AMOUNT SOURCE

2. Income other than from employment or operation of business

None ☐

State the amount of income received by the debtor other than from employment, trade, profession, operation of the debtor's business during the **two years** immediately preceding the commencement of this case. Give particulars. If a joint petition is filed, state income for each spouse separately. (Married debtors filing under chapter 12 or chapter 13 must state income for each spouse whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

AMOUNT	SOURCE

3. Payments to creditors

Complete a. or b., as appropriate, and c.

None ☐

a. *Individual or joint debtor(s) with primarily consumer debts:* List all payments on loans, installment purchases of goods or services, and other debts to any creditor made within **90 days** immediately preceding the commencement of this case if the aggregate value of all property that constitutes or is affected by such transfer is not less than $600. Indicate with an asterisk (*) any payments that were made to a creditor on account of a domestic support obligation or as part of an alternative repayment schedule under a plan by an approved nonprofit budgeting and creditor counseling agency. (Married debtors filing under chapter 12 or chapter 13 must include payments by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CREDITOR	DATES OF PAYMENTS	AMOUNT PAID	AMOUNT STILL OWING

None ☐

b. *Debtor whose debts are not primarily consumer debts:* List each payment or other transfer to any creditor made within **90** days immediately preceding the commencement of the case if the aggregate value of all property that constitutes or is affected by snch transfer is not less than $5,475. (Married debtors filing under chapter 12 or chapter 13 must include payments and other transfers by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CREDITOR	DATES OF PAYMENTS/ TRANSFERS	AMOUNT PAID OR VALUE OF TRANSFERS	AMOUNT STILL OWING

None ☐

c. *All debtors:* List all payments made within **one year** immediately preceding the commencement of this case to or for the benefit of creditors who are or were insiders. (Married debtors filing under chapter 12 or chapter 13 must include payments by either or both sponses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CREDITOR AND RELATIONSHIP TO DEBTOR	DATE OF PAYMENT	AMOUNT PAID	AMOUNT STILL OWING

4. Suits and administrative proceedings, executions, garnishments and attachments

None ☐ a. List all suits and administrative proceedings to which the debtor is or was a party within **one year** immediately preceding the filing of this bankruptcy case. (Married debtors filing under chapter 12 or chapter 13 must include information concerning either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

CAPTION OF SUIT AND CASE NUMBER	NATURE OF PROCEEDING	COURT OR AGENCY AND LOCATION	STATUS OR DISPOSITION

None ☐ b. Describe all property that has been attached, garnished or seized under any legal or equitable process within **one year** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include information concerning property of either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF PERSON FOR WHOSE BENEFIT PROPERTY WAS SEIZED	DATE OF SEIZURE	DESCRIPTION AND VALUE OF PROPERTY

5. Repossessions, foreclosures and returns

None ☐ List all property that has been repossessed by a creditor, sold at a foreclosure sale, transferred through a deed in lieu of foreclosure or returned to the seller, within **one year** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include information concerning property of either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CREDITOR OR SELLER	DATE OF REPOSSESSION, FORECLOSURE SALE, TRANSFER OR RETURN	DESCRIPTION AND VALUE OF PROPERTY

6. Assignments and receiverships

None ☐ a. Describe any assignment of property for the benefit of creditors made within **120 days** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include any assignment by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF ASSIGNEE	DATE OF ASSIGNMENT	TERMS OF ASSIGNMENT OR SETTLEMENT

None ☐ b. List all property which has been in the hands of a custodian, receiver, or court-appointed official within **one year** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include information concerning property of either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CUSTODIAN	NAME AND LOCATION OF COURT CASE TITLE & NUMBER	DATE OF ORDER	DESCRIPTION AND VALUE Of PROPERTY

7. Gifts

None ☐ List all gifts or charitable contributions made within **one year** immediately preceding the commencement of this case except ordinary and usual gifts to family members aggregating less than $200 in value per individual family member and charitable contributions aggregating less than $100 per recipient. (Married debtors filing under chapter 12 or chapter 13 must include gifts or contributions by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF PERSON OR ORGANIZATION	RELATIONSHIP TO DEBTOR, IF ANY	DATE OF GIFT	DESCRIPTION AND VALUE OF GIFT

8. Losses

None ☐ List all losses from fire, theft, other casualty or gambling within **one year** immediately preceding the commencement of this case **or since the commencement of this case**. (Married debtors filing under chapter 12 or chapter 13 must include losses by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

DESCRIPTION AND VALUE OF PROPERTY	DESCRIPTION OF CIRCUMSTANCES AND, IF LOSS WAS COVERED IN WHOLE OR IN PART BY INSURANCE, GIVE PARTICULARS	DATE OF LOSS

9. Payments related to debt counseling or bankruptcy

None ☐ List all payments made or property transferred by or on behalf of the debtor to any persons, including attorneys, for consultation concerning debt consolidation, relief under the bankruptcy law or preparation of a petition in bankruptcy within **one year** immediately preceding the commencement of this case.

NAME AND ADDRESS OF PAYEE	DATE OF PAYMENT, NAME OF PAYER IF OTHER THAN DEBTOR	AMOUNT OF MONEY OR DESCRIPTION AND VALUE OF PROPERTY

10. Other transfers

None ☐ a. List all other property, other than property transferred in the ordinary course of the business or financial affairs of the debtor, transferred either absolutely or as security within **two years** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include transfers by either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF TRANSFEREE, RELATIONSHIP TO DEBTOR	DATE	DESCRIBE PROPERTY TRANSFERRED AND VALUE RECEIVED

None ☐ b. List all property transferred by the debtor within **ten years** immediately preceding the commencement of this case to a self-settled trust or similar device of which the debtor is a beneficiary.

NAME OF TRUST OR OTHER DEVICE	DATE(S) OF TRANSFER(S)	AMOUNT OF MONEY OR DESCRIPTION AND VALUE OF PROPERTY OR DEBTOR'S INTEREST IN PROPERTY

11. Closed financial accounts

None ☐ List all financial accounts and instruments held in the name of the debtor or for the benefit of the debtor which were closed, sold, or otherwise transferred within **one year** immediately preceding the commencement of this case. Include checking, savings, or other financial accounts, certificates of deposit, or other instruments; shares and share accounts held in banks, credit unions, pension funds, cooperatives, associations, brokerage houses and other financial institutions. (Married debtors filing under chapter 12 or chapter 13 must include information concerning accounts or instruments held by or for either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF INSTITUTION	TYPE OF ACCOUNT, LAST FOUR DIGITS OF ACCOUNT NUMBER, AND AMOUNT OF FINAL BALANCE	AMOUNT AND DATE OF SALE OR CLOSING

12. Safe deposit boxes

None ☐ List each safe deposit or other box or depository in which the debtor has or had securities, cash, or other valuables within **one year** immediately preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include boxes or depositories of either or both spouses whether or not a joint petition is filed, unless the sponses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF BANK OR OTHER DEPOSITORY	NAMES AND ADDRESSES OF THOSE WITH ACCESS TO BOX OR DEPOSITORY	DESCRIPTION OF CONTENTS	DATE OF TRANSFER OR SURRENDER, IF ANY

13. Setoffs

None ☐ List all setoffs made by any creditor, including a bank, against a debt or deposit of the debtor within **90 days** preceding the commencement of this case. (Married debtors filing under chapter 12 or chapter 13 must include information concerning either or both spouses whether or not a joint petition is filed, unless the spouses are separated and a joint petition is not filed.)

NAME AND ADDRESS OF CREDITOR	DATE OF SETOFF	AMOUNT OF SETOFF

14. Property held for another person

None ☐ List all property owned by another person that the debtor holds or controls.

NAME AND ADDRESS OF OWNER	DESCRIPTION AND VALUE OF PROPERTY	LOCATION OF PROPERTY

15. Prior address of debtor

None ☐ If debtor has moved within **three years** immediately preceding the commencement of this case, list all premises which the debtor occupied during that period and vacated prior to the commencement of this case. If a joint petition is filed, report also any separate address of either spouse.

ADDRESS	NAME USED	DATES OF OCCUPANCY

16. Spouses and Former Spouses

None ☐ If the debtor resides or resided in a community property state, commonwealth, or territory (including Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin) within **eight years** immediately preceding the commencement of the case, identify the name of the debtor's spouse and of any former spouse who resides or resided with the debtor in the community property state.

NAME

17. Environmental Information.

For the purpose of this question, the following definitions apply:

"Environmental Law" means any federal, state, or local statute or regulation regulating pollution, contamination, releases of hazardous or toxic substances, wastes or material into the air, land, soil, surface water, groundwater, or other medium, including, but not limited to, statutes or regulations regulating the cleanup of these substances, wastes, or material.

"Site" means any location, facility, or property as defined under any Environmental Law, whether or not presently or formerly owned or operated by the debtor, including, but not limited to, disposal sites.

"Hazardous Material" means anything defined as a hazardous waste, hazardous substance, toxic substance, hazardous material, pollutant, or contaminant or similar term under an Environmental Law.

None ☐ a. List the name and address of every site for which the debtor has received notice in writing by a governmental unit that it may be liable or potentially liable under or in violation of an Environmental Law. Indicate the governmental unit, the date of the notice, and, if known, the Environmental Law:

SITE NAME AND ADDRESS	NAME AND ADDRESS OF GOVERNMENTAL UNIT	DATE OF NOTICE	ENVIRONMENTAL LAW

None ☐ b. List the name and address of every site for which the debtor provided notice to a governmental unit of a release of Hazardous Material. Indicate the governmental unit to which the notice was sent and the date of the notice.

SITE NAME AND ADDRESS	NAME AND ADDRESS OF GOVERNMENTAL UNIT	DATE OF NOTICE	ENVIRONMENTAL LAW

None ☐ c. List all judicial or administrative proceedings, including settlements or orders, under any Environmental Law with respect to which the debtor is or was a party. Indicate the name and address of the governmental unit that is or was a party to the proceeding, and the docket number.

NAME AND ADDRESS OF GOVERNMENTAL UNIT	DOCKET NUMBER	STATUS OR DISPOSITION

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18 . Nature, location and name of business

None ☐ a. *If the debtor is an individual*, list the names, addresses, taxpayer identification numbers, nature of the businesses, and beginning and ending dates of all businesses in which the debtor was an officer, director, partner, or managing executive of a corporation, partner in a partnership, sole proprietor, or was self-employed in a trade, profession, or other activity either full- or part-time within **six years** immediately preceding the commencement of this case, or in which the debtor owned 5 percent or more of the voting or equity securities within **six years** immediately preceding the commencement of this case.

If the debtor is a partnership, list the names, addresses, taxpayer identification numbers, nature of the businesses, and beginning and ending dates of all businesses in which the debtor was a partner or owned 5 percent or more of the voting or equity securities, within **six years** immediately preceding the commencement of this case.

If the debtor is a corporation, list the names, addresses, taxpayer identification numbers, nature of the businesses, and beginning and ending dates of all businesses in which the debtor was a partner or owned 5 percent or more of the voting or equity securities within **six years** immediately preceding the commencement of this case.

NAME	LAST FOUR DIGITS OF SOC. SEC. NO./ COMPLETE EIN OR OTHER TAXPAYER I.D. NO.	ADDRESS	NATURE OF BUSINESS	BEGINNING AND ENDING DATES

None ☐ b. Identify any business listed in response to subdivision a., above, that is "single asset real estate" as defined in 11 U.S.C. § 101.

NAME	ADDRESS

The following questions are to be completed by every debtor that is a corporation or partnership and by any individual debtor who is or has been, within **six years** immediately preceding the commencement of this case, any of the following: an officer, director, managing executive, or owner of more than 5 percent of the voting or equity securities of a corporation; a partner, other than a limited partner, of a partnership, a sole proprietor, or self-employed in a trade, profession, or other activity, either full- or part-time.

*(An individual or joint debtor should complete this portion of the statement **only** if the debtor is or has been in business, as defined above, within six years immediately preceding the commencement of this case. A debtor who has not been in business within those six years should go directly to the signature page.)*

19. Books, records and financial statements

None ☐ a. List all bookkeepers and accountants who within **two years** immediately preceding the filing of this bankruptcy case kept or supervised the keeping of books of account and records of the debtor.

NAME AND ADDRESS	DATES SERVICES RENDERED

None ☐ b. List all firms or individuals who within **two years** immediately preceding the filing of this bankruptcy case have audited the books of account and records, or prepared a financial statement of the debtor.

NAME	ADDRESS	DATES SERVICES RENDERED

None ☐ c. List all firms or individuals who at the time of the commencement of this case were in possession of the books of account and records of the debtor. If any of the books of account and records are not available, explain.

NAME	ADDRESS

None ☐ d. List all financial institutions, creditors and other parties, including mercantile and trade agencies, to whom a financial statement was issued by the debtor within **two years** immediately preceding the commencement of this case.

NAME AND ADDRESS	DATE ISSUED

20. Inventories

None ☐ a. List the dates of the last two inventories taken of your property, the name of the person who supervised the taking of each inventory, and the dollar amount and basis of each inventory.

DATE OF INVENTORY	INVENTORY SUPERVISOR	DOLLAR AMOUNT OF INVENTORY (Specify cost, market or other basis)

None ☐ b. List the name and address of the person having possession of the records of each of the inventories reported in a., above.

DATE OF INVENTORY	NAME AND ADDRESSES OF CUSTODIAN OF INVENTORY RECORDS

21 . Current Partners, Officers, Directors and Shareholders

None ☐ a. If the debtor is a partnership, list the nature and percentage of partnership interest of each member of the partnership.

NAME AND ADDRESS	NATURE OF INTEREST	PERCENTAGE OF INTEREST

None ☐ b. If the debtor is a corporation, list all officers and directors of the corporation, and each stockholder who directly or indirectly owns, controls, or holds 5 percent or more of the voting or equity securities of the corporation.

NAME AND ADDRESS	TITLE	NATURE AND PERCENTAGE OF STOCK OWNERSHIP

22 . Former partners, officers, directors and shareholders

None ☐ a. If the debtor is a partnership, list each member who withdrew from the partnership within **one year** immediately preceding the commencement of this case.

NAME	ADDRESS	DATE OF WITHDRAWAL

None ☐ b. If the debtor is a corporation, list all officers, or directors whose relationship with the corporation terminated within **one year** immediately preceding the commencement of this case.

NAME AND ADDRESS	TITLE	DATE OF TERMINATION

23 . Withdrawals from a partnership or distributions by a corporation

None ☐ If the debtor is a partnership or corporation, list all withdrawals or distributions credited or given to an insider, including compensation in any form, bonuses, loans, stock redemptions, options exercised and any other perquisite during **one year** immediately preceding the commencement of this case.

NAME & ADDRESS OF RECIPIENT, RELATIONSHIP TO DEBTOR	DATE AND PURPOSE OF WITHDRAWAL	AMOUNT OF MONEY OR DESCRIPTION AND VALUE OF PROPERTY

24. Tax Consolidation Group.

None ☐ If the debtor is a corporation, list the name and federal taxpayer identification number of the parent corporation of any consolidated group for tax purposes of which the debtor has been a member at any time within **six years** immediately preceding the commencement of the case.

NAME OF PARENT CORPORATION	TAXPAYER IDENTIFICATION NUMBER (EIN)

25. Pension Funds.

None ☐ If the debtor is not an individual, list the name and federal taxpayer identification number of any pension fund to which the debtor, as an employer, has been responsible for contributing at any time within **six years** immediately preceding the commencement of the case.

NAME OF PENSION FUND	TAXPAYER IDENTIFICATION NUMBER (EIN)

* * * * * *

[If completed by an individual or individual and spouse]

I declare under penalty of perjury that I have read the answers contained in the foregoing statement of financial affairs and any attachments thereto and that they are true and correct.

Date _____ Signature _____
of Debtor

Date _____ Signature _____
of Joint Debtor
(if any)

[If completed on behalf of a partnership or corporation]

I, declare under penalty of perjury that I have read the answers contained in the foregoing statement of financial affairs and any attachments thereto and that they are true and correct to the best of my knowledge, information and belief.

Date _____ Signature _____

_____
Print Name and Title

[An individual signing on behalf of a partnership or corporation must indicate position or relationship to debtor.]

____ continuation sheets attached

Penalty for making a false statement: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571

DECLARATION AND SIGNATURE OF NON-ATTORNEY BANKRUPTCY PETITION PREPARER (See 11 U.S.C. § 110)

I declare under penalty of perjury that: (1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110; (2) I prepared this document for compensation and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h), and 342(b); and, (3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110(h) setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required by that section.

_____ _____
Printed or Typed Name and Title, if any, of Bankruptcy Petition Preparer Social Security No.(Required by 11 U.S.C. § 110.)

If the bankruptcy petition preparer is not an individual, state the name, title (if any), address, and social security number of the officer, principal, responsible person, or partner who signs this document.

_____

_____
Address

X _____ _____
Signature of Bankruptcy Petition Preparer Date

Names and Social Security numbers of all other individuals who prepared or assisted in preparing this document unless the bankruptcy petition preparer is not an individual:

If more than one person prepared this document, attach additional signed sheets conforming to the appropriate Official Form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both. 18 U.S.C. § 156.

Form 8
(10/05)

United States Bankruptcy Court

_____ District Of _____

In re _____,
Debtor

Case No. _____
Chapter 7

CHAPTER 7 INDIVIDUAL DEBTOR'S STATEMENT OF INTENTION

☐ I have filed a schedule of assets and liabilities which includes debts secured by property of the estate.
☐ I have filed a schedule of executory contracts and unexpired leases which includes personal property subject to an unexpired lease.
☐ I intend to do the following with respect to the property of the estate which secures those debts or is subject to a lease:

Description of Secured Property	Creditor's Name	Property will be Surrendered	Property is claimed as exempt	Property will be redeemed pursuant to 11 U.S.C. § 722	Debt will be reaffirmed pursuant to 11 U.S.C. § 524(c)

Description of Leased Property	Lessor's Name	Lease will be assumed pursuant to 11 U.S.C. § 362(h)(1)(A)

Date: _____

_____
Signature of Debtor

DECLARATION OF NON-ATTORNEY BANKRUPTCY PETITION PREPARER (See 11 U.S.C. § 110)

I declare under penalty of perjury that: (1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110; (2) I prepared this document for compensation and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h), and 342(b); and, (3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110(h) setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required in that section.

_____ _____
Printed or Typed Name of Bankruptcy Petition Preparer Social Security No. (Required under 11 U.S.C. § 110.)

If the bankruptcy petition preparer is not an individual, state the name, title (if any), address, and social security number of the officer, principal, responsible person or partner who signs this document.

_____

_____
Address

X_____ _____
Signature of Bankruptcy Petition Preparer Date

Names and Social Security Numbers of all other individuals who prepared or assisted in preparing this document unless the bankruptcy petition preparer is not an individual:

If more than one person prepared this document, attach additional signed sheets conforming to the appropriate Official Form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both. 11 U.S.C. § 110; 18 U.S.C. § 156.

Form B 21 Official Form 21
(12/03)

FORM 21. STATEMENT OF SOCIAL SECURITY NUMBER

[*Caption as in Form 16A.*]

STATEMENT OF SOCIAL SECURITY NUMBER(S)

1.Name of Debtor (enter Last, First, Middle):_____
(Check the appropriate box and, if applicable, provide the required information.)

/ /Debtor has a Social Security Number and it is: _ _ _-_ _-_ _ _ _
(If more than one, state all.)
/ /Debtor does not have a Social Security Number.

2.Name of Joint Debtor (enter Last, First, Middle):_____
(Check the appropriate box and, if applicable, provide the required information.)

/ /Joint Debtor has a Social Security Number and it is: _ _ _-_ _-_ _ _ _
(If more than one, state all.)
/ /Joint Debtor does not have a Social Security Number.

I declare under penalty of perjury that the foregoing is true and correct.

X _____
Signature of Debtor Date

X _____
Signature of Joint Debtor Date

**Joint debtors must provide information for both spouses.*
Penalty for making a false statement: Fine of up to $250,000 or up to 5 years imprisonment or both. 18 U.S.C. §§ 152 and 3571.

Official Form 23 (10/06)

United States Bankruptcy Court

_____ District Of _____

In re _____, Case No. _____
Debtor

Chapter _____

DEBTOR'S CERTIFICATION OF COMPLETION OF INSTRUCTIONAL COURSE CONCERNING PERSONAL FINANCIAL MANAGEMENT

Every individual debtor in a chapter 7 or chapter 13 case must file this certification. If a joint petition is filed, each spouse must complete and file a separate certification. Complete one of the following statements and file by the deadline stated below:

☐ I, _____, the debtor in the above-styled case, hereby
(Printed Name of Debtor)
certify that on _____ (Date), I completed an instructional course in personal financial management provided by _____, an approved personal financial
(Name of Provider)
management provider.

Certificate No. : _____.

☐ I, _____, the debtor in the above-styled case, hereby
(Printed Name of Debtor)
certify that no personal financial management course is required because of *[Check the appropriate box.]*:

☐ Incapacity or disability, as defined in 11 U.S.C. § 109(h);
☐ Active military duty in a military combat zone; or
☐ Residence in a district in which the United States trustee (or bankruptcy administrator) has determined that the approved instructional courses are not adequate at this time to serve the additional individuals who would otherwise be required to complete such courses.

Signature of Debtor: _____

Date: _____

Instructions: Use this form only to certify whether you completed a course in personal financial management. (Fed. R. Bankr. P. 1007(b)(7).) Do NOT use this form to file the certificate given to you by your prepetition credit counseling provider and do NOT include with the petition when filing your case.

Filing Deadlines: In a chapter 7 case, file within 45 days of the first date set for the meeting of creditors under § 341 of the Bankruptcy Code. In a chapter 13 case, file no later than the last payment made by the debtor as required by the plan or the filing of a motion for entry of a discharge under § 1328(b) of the Code. (See Fed. R. Bankr. P. 1007(c).)

POST-HEARING QUESTIONS SUBMITTED TO THE WITNESSES

Questions for Professor Todd Zywicki

1. Over the nearly eight years that 2005 Amendments to the Bankruptcy Code were under consideration by Congress, we continuously heard that each American family was paying a $400 to $550 "bankruptcy tax" for profligate bankruptcy filings.

   Since the enactment of the Act two years ago, have interest rates dropped?

   Has the cost of goods and services been lowered in response to the perceived savings resulting from the enactment of the 2005 bankruptcy reforms?

2. Earlier this year, Steve Bartlett testified on behalf of the Financial Services Roundtable before this Subcommittee that the "total cost savings to the American economy" as a result of the enactment of the 2005 Amendments to the Bankruptcy Code to be "around $60 billion."

   Do you concur with this estimate?

   Where have Americans experienced these tremendous savings?

   For example, are interest rates lower now than they were before the 2005 Act became law?

   Are the prices of goods and services lower now?

3. How do you respond to the concerns of consumer advocates that the associated fees for filing a bankruptcy petition continue to hurt disproportionately those families forced to file for bankruptcy due to job loss, divorce, or worse, illness?

4. How do you respond to the concerns of consumer advocates that the credit counseling requirement simply creates an unnecessary hurdle for many debtors who must eventually file for bankruptcy protection?

5. Although you question the Harvard study, you appear to consider other studies that conclude about 17 percent of bankruptcy cases are filed as a result of medical debt.

   Is nearly one-fifth of bankruptcy filings prompted by medical debt an insignificant number?

Questions for Cliff White, III
Executive Office for United States Trustees

1. Do you support making bankruptcy less costly for honest, lower income debtors?

2. Earlier this year, Henry Sommer, President of the National Association of Consumer Bankruptcy Attorneys, testified before this Subcommittee that the U.S. Trustee Program "has done virtually nothing to address" abuses by creditors in the bankruptcy system.

   What is your response?

3. In your prepared statement, you state that approximately 8% of chapter 7 debtors have income above the state median income. Of those, only 12% were presumed abusive.

   This means that less than 1% of chapter 7 cases are even presumed to be abusive. Is that correct?

   Can you approximate what the cost of implementing the 2005 Amendments has been to achieve this result?

4. Why is it that up to one-fifth of presumed abusive chapter 7 cases are not pursued because of medical expenses or loss of income from illness or injury? Should the means test forms be revised so that these cases will not be presumed to be abusive?

5. As you know, medical debt is not clearly identified in a debtor's schedules as such. Often, a debtor will incur credit card debt or refinance his or her home mortgage to pay such debt.

   Thus, how could your office determine the percentage of cases that presented medical debt without interviewing the debtors as Professors Warren and Himmelstein did?

Questions for Professor Elizabeth Warren

1. Please explain the relationship between medical debt and subprime mortgages.

2. Critics of your study assert that its conclusions are unrealistic and that you and your colleagues "fail to provide a causal relationship to support the claim that medical spending contributes to 'half of all bankruptcies.'" Based on their analysis of the researchers' data, the critics were able to find a "causal link in only 17 percent of personal bankruptcies."

   What is your response to this criticism?

3. Critics of your study also question whether it substantiates your assertion that national health insurance would greatly reduce the number of bankruptcies filed as a result of medical debt.

   What is your response?

4. Professor Zywicki asserts that "American households should be much more resilient to temporary income interruptions than in previous years."

   What is your response?

5. Professor Zywicki asserts that the "increasing number of two wage-earner families obviously has made families more resilient in the face of the loss of one income as the result of job interruptions from health problems or any other source."

   What is your response?

6. Professor Zywicki states that "[m]ost studies of bankruptcy filers have failed to find a relationship between health debt and bankruptcy, although medical debt does play a role in some bankruptcy filings."

   What is your response?

7. Professor Zywicki states that he has been "unable to locate any independent researcher unaffiliated with any of the authors of [your] study who has endorsed the methodology or findings of this study."

   What is your response?

8. Professor Zywicki criticizes your study for including as "medical bankruptcies" such

events as gambling addiction, a death in the family, or the birth or adoption of a child.

What is your response?

9. Professor Zywicki states that the 2005 Amendments to the Bankruptcy Code "has cut bankruptcy filings in half, primarily by deterring fraudulent and abusive filings while preserving bankruptcy relief for those who need it."

What is your response?

10. Professor Zywicki states that the current bankruptcy system is "well-equipped to deal with the challenges of medical bankruptcies."

What is your response?

11. In what respects would you recommend amending the Bankruptcy Code to better accommodate debtors with serious medical problems?

12. Earlier this year, Henry Sommer, President of the National Association of Consumer Bankruptcy Attorneys, testified before this Subcommittee that "[b]ankruptcy has gone from being a relatively low-priced proceeding that could be handled quickly and efficiently to being an expensive minefield of new requirements, tricks and traps that catch the innocent and unsuspecting debtor."

What is your response?

13. The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 requires consumers to submit in connection with their bankruptcy cases extensive documentation, such as tax returns, payment advices, and bank statements, among other documents.

What happens if a debtor simply does not have these documents?

14. How many Americans in 2006 would you estimate have medical debt?

How many Americans would you estimate declared bankruptcy as the result of medical debt in 2006?

15. Professor Zywicki in his prepared statement states that "[f]or every innocent debtor who

has found himself down on his luck as the result of illness and injury, there are also innocent doctors, nurses, and health care professionals who have provided ameliorating and even life-saving care for the debtor." He continues, "Every $100,000 discharged rather than paid in bankruptcy may be the difference between a hospital hiring a new nurse or the ability of a doctor to afford indigent care for another patient."

What is your response?

16. Professor Zywicki states that "current law adequately accommodates the claims of those debtors laid low by medical problems and expenses and other innocent parties who are affected by bankruptcy including health care professionals and other consumers."

What is your response?

Questions for Mark Rukavina

1. Please explain why Americans, such as Ms. Smith, are not unique.

2. Please explain how a family with full insurance can still face financial distress as a result of medical debt.

3. Please explain some of the shortcomings of our current health insurance system.

4. It is asserted that certain characteristics of health insurance plans put insured people at greater risk of experiencing financial distress as result of medical debt. Please explain what these characteristics are.

5. Professor Zywicki states that there is no "evidence that medical bankruptcies are creating any sort of crisis for the bankruptcy system or that the percentage of medical bankruptcies has been rising over time."

   What is your response?

6. Professor Zywicki cites a study by Ian Domowitz and Robert Sartain that purportedly finds little correlation between medical debt and other sources of financial distress, such as job loss or income interruption.

   What is your response?

7. Professor Zywicki states that "there is no evidence that lack of medical insurance is a major causal factor in bankruptcy filings."

   What is your response?

8. What are some of the consequences of inadequate insurance?

9. Some say that medical debt problems among the insured are likely to increase. Please explain your assessment of this concern.

10. The Access Project recently issued a report on the Massachusetts Student Health Insurance Mandate. Please summarize the report's findings.

Questions for Professor David Himmelstein

1. Given the seriousness of the medical debt and bankruptcy problem in the U.S., what can Congress do to address the crisis, both in the short term and in the long term?

2. How would passage of a single payer universal health care program, such as H.R. 676, impact the medical debt and bankruptcy crisis.

3. If federal legislation was passed that would prohibit medical debt collection agencies or medical providers from reporting medical debt on one's credit score, how would this impact the delivery of medical care to both insured and underinsured patients.

4. In countries where there are single payer universal health care systems; countries such as Taiwan, Sweden, Canada, and Switzerland, do they have any problems with medical debt and bankruptcy? If not, why is this is the case?

5. Professor Zywicki in his prepared statement states that "[f]or every innocent debtor who has found himself down on his luck as the result of illness and injury, there are also innocent doctors, nurses, and health care professionals who have provided ameliorating and even life-saving care for the debtor." He continues, "Every $100,000 discharged rather than paid in bankruptcy may be the difference between a hospital hiring a new nurse or the ability of a doctor to afford indigent care for another patient."

   What is your response?

6. How much is spent annually by hospitals, physicians, dentists, medical labs, or medical equipment companies to collect medical debt?

7. Are there any for-profit and non-profit hospitals that receive federal funds; such as Medicaid, S-CHIP or DISH payments that may be using any portion of these federal dollars in order to hire private collection agencies to collect medical debt?

8. How many private medical debt collection companies are there in America, and approximately how many of these companies are hired by medical providers to collect outstanding medical debt?

9. Approximately how many Americans each year are being pressured by medical debt companies, either by calling them, or sending them a letter in the mail, to pay back medical debt to a provider?

10. Approximately how many patients each year would you estimate are being tracked down to pay medical debt from your average medium size hospital in Boston?

11. What are the annual profit margins of the largest medical debt companies?

12. How many Americans each year with medical debt have it reported to medical debt collection agencies?

13. How many Americans do you think have had medical debt that has been reported to collection agencies?

ANSWERS TO POST-HEARING QUESTIONS FROM TODD J. ZYWICKI,
GEORGE MASON UNIVERSITY SCHOOL OF LAW, ARLINGTON, VA

Responses to Questions for Professor Todd Zywicki

1.a. Since the enactment of the Act two years ago, have interest rates dropped?

I am not aware of any empirical studies that have tried to assess whether interest rates on consumer loans have dropped. I assume that the question actually means to ask about the spread between the cost of funds and overall interest rates, as there has been a general increase in the underlying cost of funds since BAPCPA was enacted.

Previous empirical study of consumer credit pricing have found that the spread between the cost of funds and prevailing interest rates is affected by the charge-off rate on consumer loans. Thus, as charge-offs increase, the spread increases as well. *See* Adam B. Ashcraft, Astrid A. Dick, and Donald P. Morgan, *The Bankruptcy Abuse Prevention and Consumer Protection Act: Means-Testing or Mean Spirited?* Federal Reserve Bank New York (Dec. 19, 2006). To the extent that charge-offs have dropped under the Act, then the spread would shrink as well.

Of course, the idea that interest rates are the only way in which consumer lenders might pass on cost savings is just incorrect as an economic matter. For instance, lenders might also increase product quality (such as customer service) or adjust other terms. For instance, empirical research indicates that behavior-based fees (such as late fees or overlimit fees) are risk-based fees that vary according to the charge-off rate. Nadia Massoud, Anthony Saunders, and Barry Scholnick, *The Cost of Being Late: The Case of Credit Card Penalty Fees*, working paper (January 2006).

1.b. Has the cost of goods and services been lowered in response to the perceived savings resulting from the enactment of the 2005 bankruptcy reforms?

I have seen no empirical study of this question.

2.a. Do you concur with this estimate?

I have no opinion. I am not familiar with the methodology that was used to calculate this figure or how this estimate was derived. Thus, I have no opinion on its accuracy.

2.b. No opinion.

2.c. No opinion.

2.d. No opinion.

3. It is not clear to me why filing bankruptcy because of illness is "worse" than filing bankruptcy due to job loss or divorce. They all sound pretty bad to me.

As to the specific question, the Act tries to strike a balance between making sure that everyone who needs bankruptcy relief is in fact able to get it. But on the other hand, it

provides necessary safeguards to protect the efficiency and integrity of the bankruptcy system. In this sense it is no different from any other similar program, such as taxes or welfare. We have tried the "honor system" in bankruptcy and it showed itself not to work effectively. Similarly, all law-abiding people have to pay higher costs in tax compliance because we are concerned that getting rid of the IRS and compliance enforcement would lead to widespread tax fraud and concerns about the efficiency and integrity of the tax system. Obviously, the costs of tax compliance also fall hardest on those who lack the resources to hire accountants and tax preparers. Similarly, the government spends a great deal of money to prevent Medicare and insurance fraud.

It is unfortunate that bankruptcy attorneys have decided that it is necessary to raise their fees and costs in order to comply with the Act's requirements. To date, however, I am not aware of any evidence that these costs increases have had the effect of denying needy filers the ability to file bankruptcy. It is understandable, however, in that both attorneys and consumer lenders are subject to supply and demand dynamics, such that when underlying cost or risk rises, they must increase the price of their product to meet it.

4. It would be premature to pass final judgment one way or the other on the credit counseling requirement. A few things are clear. Many expressed concern that given recent problems in the consumer credit counseling industry, the counseling requirement would lead to actual harm to consumers. This plainly is not the case. According to the GAO's study, the system has provided adequate capacity, reasonable rates, and professional and timely service to consumers. Fees are waived for debtors who are unable to pay. There is no evidence of misbehavior by approved counseling providers.

As a result, the question is one of a cost-benefit analysis. There plainly is *some* benefit in terms of accomplishing the goals set out by Congress of informing bankruptcy filers of alternatives to filing bankruptcy. According to the Executive Office of the United States Trustee, at least 10 percent of those issued bankruptcy filing statistics did not file bankruptcy after receiving credit counseling. The GAO estimates that about three percent of filers who sought pre-bankruptcy counseling entered debt management programs. It thus appears that although only a modest number of consumers entered DMPs a much larger percentage chose neither to file bankruptcy nor enter a DMP after seeking counseling.

It may also be the case that the efficacy of the counseling requirement has been undermined in some situations by practices that may conform to the letter of the requirement but not its intent. For instance, there are reports of lawyers who have phones or computers in their offices, through which consumers may be able to receive pro forma credit counseling services without gaining the value of a fully independent assessment of their financial situation. Congress should encourage efforts by the Executive Office of the United States Trustee to ensure full compliance with the credit counseling requirements.

Obviously, a conclusion on the value of the pre-bankruptcy counseling requirement depends on an accurate estimate of the full benefits and costs of it. In turn, this depends

on such questions as to whether the number of those dissuaded from filing bankruptcy is at the low end of the scale (3 percent) or the high end (over 10 percent). In my opinion, there is insufficient data and it is still too early to determine whether counseling is serving its purpose of adequately informing consumers of alternatives to filing bankruptcy.

5. This is an incorrect characterization of my testimony and the evidence. There are few good studies on this topic. Several studies have estimated that health *problems* may play a role in perhaps 15-20% of bankruptcy filings. Of that 15-20% less than half of those—or less than 10%—may be the result of medical *debt* with the remainder resulting from medical problems and the consequences thereof, such as missed work. I am aware of no credible study that concludes that one-fifth of bankruptcy filings are prompted by medical *debt*. Most studies, including that of the Executive Office of the United States Trustee, concur that the percentage of bankruptcies prompted by medical *debt* are probably in the single digits.

The percentage of medical bankruptcies will likely grow over time, even though there is no evidence that the absolute number is rising. Since the enactment of the Act, the bankruptcy filing rate has been cut in half primarily by weeding out improper bankruptcy filings. Thus, filings post-Act contain a higher percentage of legitimate filings than pre-Act. Indeed, the *percentage* of medical bankruptcies may be as much as twice as high as pre-Act as a result of the halving of the filing rate. Thus, in assessing this question going forward, it is imperative to consider whether the *absolute* number of medical bankruptcies has been impacted by the Act.

ANSWERS TO POST-HEARING QUESTIONS FROM CLIFFORD J. WHITE, III, DIRECTOR, EXECUTIVE OFFICE FOR U.S. TRUSTEES, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

House Committee on the Judiciary
Subcommittee on Commercial and Administrative Law

"Working Families in Financial Crisis: Medical Debt and Bankruptcy"

Responses to Questions for
Clifford J. White III, Director, Executive Office for U.S. Trustees

1. **Do you support making bankruptcy less costly for honest, low income debtors?**

The mission of the United States Trustee Program is to promote the integrity and the efficiency of the bankruptcy system. Our goal is to ensure that the interests of all stakeholders in the system are protected, that illegal and improper practices are discouraged, and that prompt relief is available to all honest debtors. We endeavor to faithfully implement the law in a manner that ensures compliance with statutory provisions, reflects the prudent exercise of discretion, and does not unduly burden honest debtors in need of relief.

2. **Earlier this year Henry Sommer, President of the National Association of Consumer Bankruptcy Attorneys, testified before this Subcommittee that the U.S. Trustee Program "has done virtually nothing to address" abuses by creditors in the bankruptcy system. What is your response?**

The United States Trustee Program's civil enforcement activities reflect a balanced approach to addressing fraud and abuse - focusing on wrong-doing both by debtors and by those who exploit debtors. The Program combats debtor fraud and abuse primarily by seeking case dismissal if a debtor has an ability to repay debts and by seeking denial of discharge for the concealment of assets and other violations. The Program protects consumer debtors from wrongdoing by attorneys, bankruptcy petition preparers, creditors, and others by seeking a variety of remedies, including disgorgement of fees, fines, and injunctive relief.

We take seriously our responsibility to aggressively investigate and take appropriate actions against creditors who abuse the bankruptcy system, particularly when the abuse is systemic or multi-jurisdictional. In many cases, creditor abuse is best addressed by the private case trustees we appoint who object to claims or by debtor's lawyers who dispute loan agreement terms. But sometimes, the integrity of the system as a whole is at stake and it is important for the United States Trustee Program to take direct enforcement action.

Among the most recent significant cases we have litigated to redress creditor abuse are two in the Southern District of Texas. In *In re Allen*, counsel for the secured lender filed an erroneous objection to confirmation in a chapter 13 case. After the debtor notified the law firm of the error, it responded with a similarly erroneous notice of withdrawal of the objection, inaccurately stating that the debtor had filed an amended chapter 13 plan. Testimony revealed that the law firm's pleadings are computer-generated and they receive little or no attorney review. In its opinion, which assessed a sanction against creditor's counsel, the court noted

that the law firm "has complained bitterly about the participation of the U.S. Trustee in this matter . . . [The United States Trustee's] participation assured presentation of a complete factual and legal case . . . **The U.S. Trustee provided an invaluable benefit to the case and to the process by his professional participation.**" 2007 WL 1747018, slip op. at 3, n.5 (Bankr. S.D. Tex. 2007) (emphasis added).

In *In re Parsley*, Case No. 05-90374 (Bankr. S.D. Tex. 2007), still pending in the Southern District of Texas, the United States Trustee is litigating against two law firms and a national mortgage lender and servicer. The Program deployed seasoned litigators from the Executive Office and other offices throughout the country to conduct discovery involving 20 witnesses and nearly 10,000 pages of documents. The court recently heard a week of testimony, and additional hearing dates have been scheduled.

Since the passage of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA), we have reached out to many constituencies in the bankruptcy system to identify areas where our enforcement actions with regard to creditor abuse could add the most value to protect debtors and the integrity of the bankruptcy system. For example, we have met on several occasions with numerous consumer debtor advocates, including the leadership of the National Association of Consumer Bankruptcy Attorneys. Additionally, at our most recent regularly scheduled meeting of the United States Trustees, we heard a presentation from a law professor who is completing a study commissioned by the National Conference of Bankruptcy Judges on mortgage industry practices in bankruptcy cases. We are hopeful that these and other outreach efforts will continue to inform our discussion and practices in this important area.

3. **In your prepared statement, you state that approximately 8% of chapter 7 debtors have income above the state median income. Of those, only 12% were presumed abusive.**

This means that less than 1% of chapter 7 cases are even presumed to be abusive. Is that correct?

Yes, more precisely, .88 percent of all chapter 7 cases filed since the effective date of the means testing provisions of the Bankruptcy Code have been presumed abusive. Of that number, we exercised our statutory discretion to decline to file motions to dismiss in over 20 percent of the cases after consideration of the debtor's "special circumstances." Despite the high rate of declination, our rate of filing motions to dismiss is currently more than double the rate per thousand cases filed than it was prior to enactment of the BAPCPA. The United States Trustee has prevailed in 97.3 percent of the cases that were either adjudicated by the bankruptcy court or voluntarily dismissed or converted under the "presumed abuse" standard contained in 11 U.S.C. § 707(b)(2).

It is important to note that the means testing provisions provide a more objective and transparent method to make initial determinations of entitlement to chapter 7 relief. This allows debtors and their counsel to make means testing calculations before deciding whether to file for

chapter 7 versus chapter 13 relief or to seek alternatives to bankruptcy. Therefore, the one percent rate of "presumed abuse" cases may understate the impact of the statutory change.

Can you approximate what the cost of implementing the 2005 Amendments has been to achieve this result?

Following passage of the BAPCPA, the President submitted a FY 2006 budget amendment to the Congress requesting $37.2 million in additional funding for the Program to implement the provisions of the Act. The FY 2006 Appropriations Act, Pub. L. No. 109–108, included an enhancement of $26.4 million for additional BAPCPA responsibilities, including first-year funding of $15.7 million for 241 new positions to carry out the means testing provisions. The FY 2007 Appropriations Act, Pub. L. No. 110-5, provided $11 million to annualize the funding for those positions, for a total over the two years of $26.7 million. The total includes funding for salaries and benefits associated with the new positions, as well as for infrastructure and other related costs of the positions (e.g., training, travel, transit subsidies, communication costs, rent, payroll services, background investigations, furniture, office supplies, computers, and information technology).

The FY 2006 budget amendment was based on an assumption that the Program would have data-enabled form technology available to leverage the staffing resources that would otherwise be required to implement the means test. We have been working with the Administrative Office of the United States Courts and the Judicial Conference of the United States to adopt data-enabled forms as a mandatory standard of the court's electronic case filing system. The Administrative Office adopted the jointly developed data-enabled technical standard approximately two years ago, but only as an optional standard pending further study. If the Judicial Conference ultimately grants the Program's request for the adoption of data-enabled forms as a mandatory standard, bankruptcy administration will be streamlined and less costly, and policymakers will have more information to evaluate the effectiveness of the bankruptcy system.

4. **Why is it that up to one-fifth of presumed abuse chapter 7 cases are not pursued because of medical expenses or loss of income from illness or injury? Should the means test forms be revised so that these cases will not be presumed abusive?**

As reflected in the testimony, the United States Trustee Program declines to file motions to dismiss in over 20 percent of cases that are "presumed abusive" under the means testing provisions of the Bankruptcy Code. About one-fifth of those declinations were based upon a determination that dismissal was not appropriate due to circumstances relating to a medical condition. Overall, medical-related declinations are made in about 4.8 percent of presumed abuse cases.

Section 707(b)(2)(B) expressly provides that "the presumption of abuse may only be rebutted by demonstrating special circumstances, such as a serious medical condition . . . ." Among the specific reasons considered by the Program in the cases where it declined to file a motion to dismiss were job loss resulting from injury to the debtor, chronic illness of the debtor

or a debtor's family member resulting in high medical expenses for the debtor, and similar circumstances.

The means test forms promulgated by the Judicial Conference – Official Forms 22A (chapter 7) and 22C (chapter 13) – provide a place where a debtor can list additional expenses or adjustments to income reported, including those pertaining to medical circumstances. If debtors or their counsel inform the United States Trustee promptly of "special circumstances" that overcome the "presumed abuse" arising from the means test calculations, then the Program can file a declination contemporaneous with the notice it is required to file reporting that the means test calculation resulted in a determination of "presumed abuse." 11 U.S.C. § 707(b)(2). Therefore, we do not believe the official forms need to be amended at this time.

5. **As you know, medical debt is not clearly identified in a debtor's schedules as such. Often, a debtor will incur credit card debt or refinance his or her home mortgage to pay such debt.**

Thus, how could your office determine the percentage of cases that presented medical debt without interviewing the debtors as Professors Warren and Himmelstein did?

As stated in the Program's testimony, the medical debt information contained on official forms filed by debtors in bankruptcy cases generally does not indicate whether credit card, home equity loan, or other debt was incurred to pay for medical care. Certain bankruptcy forms do contain information fields, however, that could be "data tagged" to allow for cases with medical-related debt to more quickly be identified and to permit a more comprehensive analysis of incidence of medical-related debt. For example, on Schedule J, Line 7, debtors are asked to provide an estimate of their average or projected monthly "Medical and dental expenses" and to report health insurance costs on Line 11c. Additionally, on Official Form 22A, the following six lines provide relevant information:

Line 31, Other Necessary Expenses: health care
Line 34(a), Health Insurance
Line 34(b), Disability Insurance
Line 34(c), Health Savings Account
Line 35, Continued contributions to the care of household or family members (reasonable and necessary care and support of an elderly, chronically ill or disabled member of the household or immediate family members)
Line 56, Other Expenses (required for the health and welfare of the debtor and the debtor's dependents)

If these data could be extracted and aggregated from official court filings, then bankruptcy policy-makers and administrators would be able to make decisions or take actions with a better understanding of the relationship between medical costs and bankruptcy.

ANSWERS TO POST-HEARING QUESTIONS FROM ELIZABETH WARREN, HARVARD LAW SCHOOL, CAMBRIDGE, MA

Questions for Professor Elizabeth Warren

1. Please explain the relationship between medical debt and subprime mortgages.

2. Critics of your study assert that its conclusions are unrealistic and that you and your colleagues "fail to provide a causal relationship to support the claim that medical spending contributes to 'half of all bankruptcies.'" Based on their analysis of the researchers' data, the critics were able to find a "causal link in only 17 percent of personal bankruptcies."

   What is your response to this criticism?

3. Critics of your study also question whether it substantiates your assertion that national health insurance would greatly reduce the number of bankruptcies filed as a result of medical debt.

   What is your response?

4. Professor Zywicki asserts that "American households should be much more resilient to temporary income interruptions than in previous years."

   What is your response?

5. Professor Zywicki asserts that the "increasing number of two wage-earner families obviously has made families more resilient in the face of the loss of one income as the result of job interruptions from health problems or any other source."

   What is your response?

6. Professor Zywicki states that "[m]ost studies of bankruptcy filers have failed to find a relationship between health debt and bankruptcy, although medical debt does play a role in some bankruptcy filings."

   What is your response?

7. Professor Zywicki states that he has been "unable to locate any independent researcher unaffiliated with any of the authors of [your] study who has endorsed the methodology or findings of this study."

   What is your response?

8. Professor Zywicki criticizes your study for including as "medical bankruptcies" such events as gambling addiction, a death in the family, or the birth or adoption of a child.

   What is your response?

9. Professor Zywicki states that the 2005 Amendments to the Bankruptcy Code "has cut bankruptcy filings in half, primarily by deterring fraudulent and abusive filings while preserving bankruptcy relief for those who need it."

   What is your response?

10. Professor Zywicki states that the current bankruptcy system is "well-equipped to deal with the challenges of medical bankruptcies."

    What is your response?

11. In what respects would you recommend amending the Bankruptcy Code to better accommodate debtors with serious medical problems?

12. Earlier this year, Henry Sommer, President of the National Association of Consumer Bankruptcy Attorneys, testified before this Subcommittee that "[b]ankruptcy has gone from being a relatively low-priced proceeding that could be handled quickly and efficiently to being an expensive minefield of new requirements, tricks and traps that catch the innocent and unsuspecting debtor."

    What is your response?

13. The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 requires consumers to submit in connection with their bankruptcy cases extensive documentation, such as tax returns, payment advices, and bank statements, among other documents.

    What happens if a debtor simply does not have these documents?

14. How many Americans in 2006 would you estimate have medical debt?

    How many Americans would you estimate declared bankruptcy as the result of medical debt in 2006?

15. Professor Zywicki in his prepared statement states that "[f]or every innocent debtor who has found himself down on his luck as the result of illness and injury, there are also innocent doctors, nurses, and health care professionals who have provided ameliorating and even life-saving care for the debtor." He continues, "Every $100,000 discharged rather than paid in bankruptcy may be the difference between a hospital hiring a new nurse or the ability of a doctor to afford indigent care for another patient."

    What is your response?

16. Professor Zywicki states that "current law adequately accommodates

the claims of those debtors laid low by medical problems and expenses and other innocent parties who are affected by bankruptcy including health care professionals and other consumers."

What is your response?

1. Some families try to deal with overwhelming medical bills by refinancing their homes. Among the families in bankruptcy, about 2% of all families (about 4% of all homeowners) report refinancing or taking out second mortgages to pay medical bills. If these numbers were applicable across all years, then an estimated 200,000 families put their homes on the line to try to pay medical bills before they ultimately declared bankruptcy.

2. My co-authors and I responded to this piece in full. See, David Himmelstein, Deborah Thorne, Elizabeth Warren and Steffie Woolhandler, *Discounting the Debtors Will Not Make Medical Bankruptcy Disappear*, Health Affairs No. 2, 25 (2006). The critics, who were paid by the health insurance industry to launch their attack, produced no new data. Instead, they simply decided to redefine medical bankruptcy, cutting out, for example, debtors who mortgaged their homes to pay medical debts or those who ran up credit card debts to pay for medical bills. Similarly, they eliminated from the medical-bankruptcy category debtors who said they had large drug or home care costs, though not hospital or doctor bills. Redefining medical bankruptcy does not make it go away.

3. Our study makes it clear that health insurance does not protect families from the economic fallout of a serious medical problem. Fully three out of four—75.7%—medical debtors had insurance at the onset of the illness or accident that they identified as contributing to their bankruptcies. The current system provides too little protection even for those with insurance.

4. Professor Zywicki has a strong opinion that is not backed up either by independent data or by the experiences of most Americans.

5. Sharp increases in the costs of big fixed expenses have made all families more vulnerable financially. In a single generation, families are spending more just for the basics. So, for example, the size of the home purchased by the median earning family has moved from 5.8 to 6.1 rooms, but the monthly mortgage payment has increased by nearly 80% (in inflation adjusted dollars). Health insurances costs have increased 75%; transportation costs have increased 52%. The two income family also must cope with child care costs and an increase in taxes. The bottom line is that after they pay their basic expenses, today's two-income families have less cash left over than their one-income counterparts a generation ago. They are working hard, but they are more vulnerable than ever.

6. Professor Zywicki ignores the over-whelming number of studies that confirm the role of medical debt in pushing families into bankruptcy. See, for example, a study in Utah in 2004. Researchers Ezekial Johnson and James Wright studied 281 bankrupt families.[1] They discovered that 61% of families cite medical problems as a major reason for their financial troubles. They note the higher-than-average citation of medical reasons in Utah as possibly linked to the state's

[1] Ezekial Johnson and James Wright, Are Mormons Bankrupting Utah?, XL Suffolk Law Review 607 (2007).

low expenditures on health care and the increased likelihood of no health insurance for Utah families. They compare these data with other states that have lower filing rates and better support for families with medical problems.

Johnson and Wright's study followed an earlier study of Utah families in bankruptcy conducted by the Salt Lake Tribune.[2] Researchers analyzed court records for 1,053 randomly selected bankrupt families from June 2003 to June 2004, and concluded that 60% of the families were in bankruptcy because of unpaid medical bills. A more recent study of Utah families by the United Way reached a similar conclusion.[3] This statewide telephone survey of nearly 2000 households plus focus group with 55 Utah citizens concluded that healthcare and job-related factors were most cited as affecting financial stability.

In another study of bankruptcy families, Ning Zhu studied 1,667 Chapter 7 cases and 1,089 Chapter 13 cases filed in 2003 in Delaware. This project used only court record data, so it could not provide a comprehensive look at the number of bankrupt families with medical problems. But the court record data alone showed that large medical bills led to a 50% increase in the likelihood of filing for bankruptcy.

In a study of 279 bankruptcy cases filed in Champaign County, Illinois in December 2001, 58% of the filings involved medical debt. Researchers Claudia Lenhoff and Brooke Anderson noted, "This number does not include medical debt that was paid for with credit cards or by borrowing from a loan company." Claudia Lenhoff and Brooke Anderson, Champaign County Health Care Consumers' Medical Billing Task Force, Medical Debt in Champaign County (April 2003).

A recent regional study of debtors filing for bankruptcy concentrated on low-income families. Trilby de Jung studied 348 families seeking help at bankruptcy clinics in Albany, Syracuse, Rochester and Buffalo, New York in 2005.[4] Among the respondents, 58% had medical debts, and 36% experienced a loss of income associated with their medical problems.

Some researchers have focused on the financial impact of particular illnesses. A 2006 USA Today, Kaiser Family Foundation, and Harvard School of Public Health survey of households affected by cancer documented that 3% of these families had declared bankruptcy and 7% had taken a second mortgage on their homes.[5] In addition, 13% were contacted by a collection agency over their medical debts. One quarter of the families said they had used up all their savings

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[2] Utahans and Bankruptcy: Why We're Going Broke, Salt Lake Tribune A-1 (January 11, 2005).
[3] United Way of Salt Lake, Living on the Edge: Utahans Perspectives on Bankruptcy and Financial Stability (2006) (available at www.uw.org/images/PDFs/UWBKReport.pdf).
[4] Trilby de Jung, A Review of Medical Debt in Upstate New York, Empire Justice Center (January 2006).
[5] USA Today, Kaiser Family Foundation, and Harvard School of Public Health, National Survey of Households Affected by Cancer (November 2006).

dealing with the fallout from cancer, and one-tenth could not afford basics such as food, heat and housing.

Researchers Deanna L. Sharpe and Dana Lee Baker explored the financial impact of having a child with autism.[6] The authors cite several stories of uncovered health expenses and the families' increasing need to file bankruptcy.

In an American Enterprise Institute study, Aparna Mathur analyzed data from the Panel Survey of Income Dynamics, using longitudinal data to examine the relationship between medical problems and bankruptcy.[7] The PSID data focused on 74 families who admitted to filing for bankruptcy.[8] The dataset includes the debtor's explanations for why they filed for bankruptcy, but Mathur bypassed these data, examining only the reported reasons for incurring specific debts. Mathur concluded that medical debts were significantly related to bankruptcy filings, although they were often not the main reason for filing. Mathur sets the floor at 27% of bankruptcies as caused primarily by medical problems, while other debtor's medical problems, job problems and other difficulties are tangled together.

There are a number of studies that do not focus specifically on bankruptcy, but they draw the connection between medical and financial problems. In effect, these are the studies that show, at least in part, why so many families end up in medical bankruptcy. Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren conducted a national telephone survey in 2003-04 for the Commonwealth Fund.[9] They studied 4,052 households. Among the key findings:

- 77 million Americans age 19 and older—nearly two of five (37%) adults—have difficulty paying medical bills, have accrued medical debt or both within past three years.
- Working-age adults incur significantly higher rates of medical bills and debt problems than those 65 and older, highest rates among uninsured. Even those with health insurance have significant trouble.
- 2/3 of people with a medical bill or debt problem went without needed care because of cost—nearly three times the rate of those without these financial problems.

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[6] Deanna L. Sharpe and Dana Lee Baker, Financial Issues Associated with Having a Child with Autism, 28 Journal of Family Economic Issues 247 (March 9, 2007).

[7] Aparna Mathur, Medical Bills and Bankruptcy Filings, American Enterprise Institute Working Paper (July 19, 2006).

[8] The PSID purports to be a cross-section of American families, but the number o families admitting to a bankruptcy filing is about half that of the population in the year asked. This means either that the sample is not representative or that about half of those who filed for bankruptcy denied it. This discrepancy calls into question the use of the database for analyzing bankruptcy issues. See, e.g., *Less Stigma or More Financial Distress: An Empirical Analysis of the Extraordinary Increase in Bankruptcy Filings,* 59 Stanford L. Rev. 213, 245-46 (2006).

[9] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, Seeing Red: Americans Driven into Debt by Medical Bills, The Commonwealth Fund (August 2005).

- 21% of all non-elderly adults have been contacted by a collection agency over a medical bill within past 12 months. (The rates were 35% for the uninsured and 15% for those with insurance.)

How medical debt becomes credit card debt was the subject of a study by Cindy Zeldin and Mark Rukavina for the Demos Foundation and The Access Project.[10] They surveyed 1150 low and middle income households with credit card debt, documenting that 29% of those households with credit card debt reported that medical expenses contributed to their current level of credit card debt. Among the "medically indebted," the study found:

- 69% had a major medical expense in the previous three years. Within this "medically indebted" group
- 44% had credit card debt higher than $10,000 and 57% had credit card debt higher than $5,000.
- Average credit card debt for the medically-indebted was higher for low- and middle- income households ($11,623) as compared to households without a major medical expense ($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% versus 38%).

In a study conducted at ten community-based organizations in Baltimore City, Maryland in 2002, Thomas P. O'Toole, Jose J. Arbelaez, Robert S. Lawrence surveyed 274 adults.[11] They found:

- 46.2% reported currently owing money for medical care they received
- Average debt load per person was $3,409, almost half of the annual reported income.
- 39.4% reported they had been referred to a collection agency for a medical debt at some point in their lives
- Having medical debt significantly is associated with no medical insurance (60.1% v. 31.5%)

A study by Sydney D. Watson, Margarida Jorge, Andrew Cohen and Robert W. Seifert for The Access Project documented the difficulties families have in dealing with health care expenses. In 2006, they surveyed 383 working families living in the St. Louis, with incomes generally below $35,000. More than half—

[10] Cindy Zeldin and Mark Rukavina, Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses, Demos and The Access Project (2007).
[11] Thomas P. O'Toole, Jose J. Arbelaez, Robert S. Lawrence, The Baltimore Community Health Consortium, Medical Debt and Aggressive Debt Restitution Practices, 19 Journal of General Internal Medicine 772-78 (2004).

53%—of respondents currently owed money for medical care.[12] Among those who could not pay their medical debts in full, bad credit and housing problems were widespread.

7. My co-authors' and my work was published in a well-respected, peer-reviewed journal. It was anonymously reviewed, and all parts of the study—including the methodology—were scrutinized before the journal agreed to publish it. I know of none of Professor Zywicki's work that has been similarly reviewed and validated.

8. We have given every possible breakdown of the data in our published work and in the testimony before this Committee. The gambling and alcoholism responses are not counted in the report that 56% of families in bankruptcy report filing for bankruptcy in the aftermath of serious medical problems, a fact that has been clear in the published work.

9. Professor Zywicki has offered no data of any kind to support his claim that the bankruptcy amendments have eliminated only abusers from the bankruptcy system. I would be glad to review any evidence he presents.

10. Professor Zywicki has offered no data of any kind to support his claim that the bankruptcy system is capable of handling medical bankruptcies. I would be glad to review any evidence he presents.

11. Providing relief for families hard-pressed by medical bills would include lowering the barriers to entry (higher fees, higher attorney costs, the costs associated with credit counseling) and expanding relief for families at risk for losing their homes (including the ability to deal with high LTV mortgages).

12. The 2005 amendments added a number of hurdles for debtors to meet. Any increase in paperwork, procedures and expanded liability for attorneys will likely drive up total costs.

13. A debtor who cannot produce the needed documentation in a timely manner will forfeit bankruptcy protection.

14. According to the Commonwealth Fund studies, 77 million Americans age 19 and older—nearly two of five (37%) adults—have difficulty paying medical bills, have accrued medical debt or both within past three years. In the aftermath of the 2005 amendments, bankruptcy filings were sharply cut in 2006. During 2006, an estimated 300,000 families filed a medical bankruptcy.

15. The bankruptcy court records make it clear that only a small fraction of the medical debts that families have incurred are still held by the medical facility at the time of the discharge in bankruptcy. Some medical debts were paid with

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[12] Sydney D. Watson, Margarida Jorge, Andrew Cohen and Robert W. Seifert, Living in the Red: Medical Debt and Housing Security in Missouri, The Access Project (2007).

credit cards. Others were paid when debtors took out second mortgages. Still others were paid out of current income, while the debtors borrowed money to pay other living expenses. In all those cases, the family was overwhelmed by medical debt, but none of that medical debt was discharged in bankruptcy.

16. Professor Zywicki has offered no data of any kind to support his claim that the bankruptcy system is capable of handling medical bankruptcies. I would be glad to review any evidence he presents.

ANSWERS TO POST-HEARING QUESTIONS FROM MARK RUKAVINA, EXECUTIVE DIRECTOR, THE ACCESS PROJECT, BOSTON, MA

Response to written questions from the House of Representatives' Committee on the Judiciary following July 17, 2007 hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy

Submitted by Mark Rukavina, Executive Director, The Access Project.

1. Please explain why Americans, such as Ms. Smith, are not unique?

The Access Project has done extensive research on the issues of medical debt and inadequate insurance coverage. A project conducted in the year 2000 surveyed more than 10,000 uninsured individuals in two dozen communities across the country. We explored their experiences and perceptions in accessing and paying for medical care. Though this effort we developed a deeper understanding of the problem of medical debt.

Nearly half of all respondents (46%) from this 2000 survey reported having unpaid bills or being in debt to the facility where they received care. This was surprising given that the vast majority of the respondents received care at safety net facilities, which have a mission to serve uninsured and other underserved populations. This challenged the common belief that the uninsured can get the care they need, when they need it, at no cost. It also documented that while people received care, they were left with significant medical debt.[1]

Since that time, we have conducted many other research projects to examine the problem of medical debt and have found that it is widespread and has long-lasting repercussions. Time and time again, we found that those with medical debt delayed or avoided care. For example, in a survey of community health center patients in Massachusetts, 41% reported medical debt. Among those with debt, nearly three in five said that it caused them to delay getting care when they needed it.[2] A survey of farm families in Kansas found that nearly one-third (29%) of the non-elderly respondents had medical debt. Of those with medical debt, nearly (47%) said it caused them to delay or avoid needed care.[3]

Our findings are consistent with those other organizations. A national study done by the Commonwealth Fund found that one in five (21%) Americans adults under the age of 65, an estimated 36 million people, have medical bills they are paying off over time.[4] The Kaiser Family Foundation estimates that 58 million Americans are at risk of incurring medical bills they may not be able to repay.[5] Included in this figure are Americans uninsured for any part of the year and nearly 18 million people with private insurance coverage that provides them with inadequate protection. Research from both of these organizations has also made a correlation between medical debt and limited access to care.

Financial consequences also result from medical debt. In an Access Project survey of people seeking help at Volunteer Income Tax Assistance sites, we found that more than one-quarter of the respondents experienced housing problems as a result of their medical debt. Problems ranged from being unable to qualify for a mortgage, being turned down from renting a home, and even eviction or foreclosure.[6]

The national studies cited previously also document the financial consequences of medical debt. The Commonwealth Fund research found that among those with medical debt, one-quarter were unable to pay for basic necessities and one in four used up most or all of their savings trying to pay off their medical bills. For many American families, when the burden of outstanding medical bills becomes too great, they must consider the decision to file for personal bankruptcy. According to research conducted by Harvard University, approximately half of all Americans filing for personal bankruptcy do so because of a medical problem.[7] Medical problems included both the loss of income due to illness or injury and unpaid medical bills.

The various research cited above clearly illustrates that the situation faced by Ms. Smith is not unique.

2. Please explain how a family with full insurance can still face financial distress as a result of medical debt.

It is difficult to clearly define full insurance. However, recent research conducted by The Access Project indicates that even families with relatively comprehensive insurance purchased from ostensibly reputable companies can experience medical debt.[8]

Our research examining medical debt among those with insurance found that the combination of insurance policy premiums AND deductibles, co-payments or co-insurance often resulted in unaffordable medical expenses or medical debt. Families with lower incomes or chronic conditions often faced unmanageable financial burdens as a result of co-payments for medications or regular and frequent doctor visits that consumed much or all of their disposable income. We also found that annual or lifetime caps on coverage could leave people with enormous debts if they became seriously ill.

Complex cost-sharing arrangements were also a cause of medical debt. Such arrangements made it difficult for people to understand which bills were to be paid by the insurer and which were their responsibility. For this reason, people often found it hard to identify errors or to resolve insurance disputes when they thought errors had occurred. Complex arrangements also sometimes made it difficult for people to comply with required procedures, which sometimes left them liable for expenses their insurance should have covered. Sorting out these issues often took months to resolve and typically took place when respondents, or their loved ones, were ill and vulnerable.

Our research on the insured population is consistent with that of other organizations. Commonwealth Fund research estimated that approximately one in eight insured American adults is underinsured.[9] Their definition for underinsured included adults who 1) had medical expenses amounting to 10% or more of household income, 2) had medical expenses amounting to 5% or more if their household incomes were below 200% of the federal poverty level, or 3) had a health plan deductible amounting to 5% or more of household income.

The study also found that the underinsured were less likely to have coverage for prescription drugs, dental services, or vision services and that they were more likely to have higher deductibles. This research also revealed that the underinsured delayed care and experienced financial distress at rates similar to the uninsured

3. Please explain some of the shortcomings of the current health insurance system.

As the cost of health care escalates so, too, does the amount charged for health insurance premiums. A newly released survey from the Kaiser Family Foundation found that the cost of health insurance premiums increased by 78% since 2001, while wages increased by only 19%.[10] High premiums cause employers and individuals to drop coverage.

Increasing health insurance premiums have also resulted in a redesign of insurance products, many of which offer lower premiums in exchange for less comprehensive benefits and much higher deductibles, co-payments, and other forms of cost sharing. New insurance products also include tax-sheltered health savings accounts that are coupled with high deductible plans. Some policymakers believe that such products will be effective in containing costs. They believe that if patients have to pay for more of their care, they will become more prudent purchasers of care and thus drive down costs. Such products are also often appealing to employers struggling to maintain coverage as health care costs continue to climb.

While these products are intended as affordable options for the uninsured, The Access Project questions their effectiveness, especially for low income populations with limited resources. While these approaches may provide some relief to employers purchasing coverage, they do not contain the cost of health care but rather shift it to the patient. This cost shifting will inevitably exacerbate the problem of medical debt.

Another problem with the current system is that large insurers control the market in many parts of the county. The health insurance industry has experienced significant consolidation as a result of mergers and acquisitions. According to one report, a single insurer controls one-half or more of the market for HMOs and PPOs, the most commonly purchased insurance products, in more than half (56%) of the 294 metropolitan areas studied.[11] United Health Group has acquired more than 30 health insurance firms since 1991. WellPoint and United, the two largest for-profit insurers, now control one third of the commercial health insurance market nationally. Consolidation is not limited to the for-profit sector. According to a GAO report, nonprofit Blue Cross Blue Shield plans now control more than half of the market in at least nine states.[12]

It is not surprising, given this level of market consolidation, that insurers' profits and reserves have risen dramatically. United Health Group's revenues rose from $23 billion in 2001 to over $45 billion in 2005,[13] while Blue Cross Blue Shield (BCBS) plans have seen rapid increases in their surpluses and reserves. In Rhode Island, BCBS reserves grew by $150 million since 1999, at the same time that premiums approximately doubled.[14] In Washington State, reserves at two BCBS plans increased by 60 percent or

more between 2000 and 2004.[15] In 2005, BCBS cash reserves in Massachusetts exceeded $1.2 billion,[16] while in Pennsylvania, the reserves of the four BCBS plans topped $4 billion.[17]

Unfortunately for those buying health insurance, consolidation and healthy margins have not resulted in a lowering of premiums. The reported figures in the financial statements of the publicly traded companies reveal that a smaller portion of the health premium dollar is going toward paying medical claims. Over the past five years, United Health Group has gone from paying 85 cents on the dollar on medical care to barely over 80 cents;[18] thus one fifth of the premiums they receive are paying for administrative overhead and marketing fees as well as profits. Clearly, the fact that smaller portions of the premium dollar are being used to pay for patient care reflects inefficiency and represents a shortcoming of our health insurance system. Recent news reports indicate that products sold to smaller employers have been a particular gold mine for United Health and its rivals in recent years, as medical inflation has eased but insurers continue to raise premiums at double-digit rates. [19]

4. It is asserted that certain characteristics of health insurance plans put insured people at greater risk for experiencing financial distress as a result of medical debt. Please explain what these characteristics are.

As mentioned in response to question 2, we have examined the issue of medical debt among those with insurance. Some of the characteristics we identified as contributing to medical debt include high premiums, deductibles, co-payments and co-insurance; benefit caps; and complexity of coverage and cost sharing requirements..

For some people, the cost of premiums can lead to medical debt., National research has found that health insurance premiums alone account for at least 5% of annual income for nearly one in five insured adults.[20] This figure jumps to nearly one-half among adults who are underinsured. With premiums absorbing such high levels of family incomes, there is often limited disposable income left should one experience illness or injury and require treatment.

Access Project research examining medical debt among those with insurance has found that cost sharing in the form of deductibles, co-payments and co-insurance can also lead to medical debt. People are particularly prone to facing unexpectedly high medical expenses if their insurance policies require co-insurance. Co-insurance requires patients to pay a certain percentage of the cost of care. Many of the individuals we spoke with were shocked by the size of the bills they incurred because of co-insurance.

Benefit caps represent another problematic insurance characteristic; they include lifetime caps, annual caps, per illness or injury caps, or caps for certain services. According to the insurance industry, only a small percentage of patients exceed caps. However, for those reaching these caps, the result can lead to financial catastrophe and an inability to access further treatment.

The complexity of health insurance with respect to cost-sharing arrangements, billing, policies and procedures is also a serious problem. In our research we found that when people tried to clarify bills, they often received incomplete or inconsistent information from their insurance companies. As a result, people sometimes sought care that they thought their insurance would cover, only to find that the claims were denied because of fine-print policy provisions or procedural requirements. In other cases, insurers' refused to pay for services that should have been covered. Sorting out problems could take months and the investment of incredible amounts of energy, often at a time when people were also dealing with serious illness.

Sometimes, unexpected expenses resulted from treatment provided by an out-of-network provider. Frequently, patients were unclear about which providers were included in a given network. For example, in some cases a patients received care at a hospital that was in their network, but were treated at the hospital by a physician who was not in their network.

For all of the reasons cited above, we have found that for many people health insurance does not fulfill its primary function, which is to allow them to access needed care when they get sick without suffering overwhelming financial losses.

5. Professor Zywicki states that there is no "evidence that medical bankruptcies are creating any sort of crisis for the bankruptcy system or that the percentage of medical bankruptcies has been rising over time." What is your response?

I disagree with Professor Zywicki's claim. Research conducted by Harvard University found that illness or medical bills was a major contributing factor in nearly half of all personal bankruptcies. The findings of the Harvard study may differ from Professor Zywicki's because the Harvard researchers gathered more detailed information from respondents on the context and original source of their debt.

Medical debt, like all forms of debt, is fungible. For example, from research conducted by The Access Project and others we know that many people put medical bills on their credit cards. In a bankruptcy filing, these bills might be categorized as credit card or consumer debt, even though their original source was medical expenses. The research conducted by Harvard University was designed to reveal this type of often overlooked medical debt.

In addition, in interviews conducted by The Access Project with various experts on personal bankruptcy, including Clerks of US Bankruptcy Courts, Bankruptcy Trustees and members of the private bar representing individual filers, we have consistently heard that medical debt and medical incidents are among the top two or three factors contributing to personal bankruptcy.

In the surveys conducted by The Access Project on medical debt, typically only a small percentage of respondents have filed for bankruptcy as a result of incurring medical debt. However, other aspects of our research indicate that bankruptcy often represents the last

resort of people trying to deal with unaffordable medical bills.. We asked people with medical debt about the sources they used to pay off medical bills . We found that many had exhausted their savings, borrowed from friends and family, charged medical expenses to their credit cards, taken out loans, or borrowed against a home in order to pay off medical expenses.[21] For those who had exhausted all of these avenues, bankruptcy was often the only alternative.

With regard to whether the percentage of medical bankruptcies has been increasing over time, we would again refer to the research done by Harvard University.

6. Professor Zywicki cites a study by Domowitz and Sartain that purportedly finds little correlation between medical debt and other sources of financial distress, such as job loss or income interruption. What is your response?

Access Project research challenges the claim that there is no correlation between medical debt and other sources of financial distress. In a study conducted in conjunction with a Consumer Credit Counseling Service of Palm Beach, Florida,[22] credit counselors asked people seeking their services whether a medical problem was part of the reason they sought credit counseling, and whether paying for medical bills caused them to delay paying for other bills.

The result surprised even the counselors. Approximately 40% of respondents said that a medical problem contributed to their debt. Medical problems included both medical debt and loss of income due to limits on a person's ability to work. Almost one-third (30%) of the respondents stated that the medical problem left them with unaffordable bills, two in five (42%) said it limited their ability to work, and more than one-quarter (28%) said that they both incurred medical debt and were limited in their ability to work.

Because the vast majority of Americans secure health care coverage through employment, the loss of a job can also lead to the loss of health insurance and thus greater risk for medical debt.. This in itself suggests a strong correlation between medical debt and job loss.

7. Professor Zywicki stated that "there is no evidence that lack of medical insurance is a major causal factor in bankruptcy filings?" What is your response?

Our research and that of others clearly documents that the uninsured are far more likely to incur medical debt than those with insurance. This seems intuitively obvious since the uninsured are expected to pay the entire cost for any care they receive.

One national study found that more than one-quarter of the uninsured had medial debt compared to just under one-fifth of those with insurance. The amounts of debt also varied between these groups. The uninsured were twice as likely as the insured to have outstanding medical debt of $8,000 or more. . Just under half of the uninsured with medical debt used up all of their savings trying to pay it off, compared to one-third of those with insurance.[23]

Another national study found that among low income households carrying credit card debt, nearly one-third reported that medical expenses contributed to the level of debt. Among those reporting medical expenses as a factor, the average credit card debt was significantly higher ($14,512) for those without insurance than those with coverage ($10,973).[24]

These data suggest that while insurance does not necessarily protect people from financial hardship resulting from medical bills, it does make it less likely that they will experience this problem..

8. What are some of the consequences of inadequate insurance?

Inadequate insurance can be a barrier to needed medical care and it result in serious financial problems for those who experience illness or injury.

A large body of research documents that the care seeking behaviors of the uninsured differs significantly from those with insurance. For example, the uninsured are far more likely to delay care, forego treatment, or skip medications than those with insurance. However, a great deal of recent research indicates that inadequate insurance also creates barriers to accessing care. One national study found that the underinsured were at least three times more likely to skip a test or treatment, forgo a follow-up appointment recommended by a physician, or not visit a clinician in spite of having a medical problem than those with more comprehensive insurance coverage. [25]

Another national study found that insured Americans with medical debt are as likely to postpone care due to cost as are the uninsured, while both groups are nearly five times more likely to postpone care than those with insurance but no medical debt.[26]

Inadequate insurance coverage is also associated with serious financial consequences. The underinsured are far more likely to incur debt, be contacted by a collection agent, or change their way of life in order to repay medical debt than are those with better insurance.[27]

9. Some say that medical debt problems among the insured are likely to increase. Please explain your assessment of this concern.

As health care costs escalate and health insurance coverage diminishes, insurers are increasingly shifting the cost of care to patients. A study of increases in health insurance premiums in 2007 found that premiums increased at twice the rate of inflation. One article reporting on the study findings said,. "Premiums would climb even higher… if [employers] didn't plan to increase employees' deductibles and introduce other cost-sharing measures.[28] Given that these additional costs come on top of a large increase in premiums, it is almost certain that more insured people will incur medical debt.

Now that national household surveys are regularly gathering data on medical debt, it will be possible to track the number of Americans with medical debt over time These data will provide an important measure of the effectiveness of insurance coverage in guaranteeing people access to health care and protecting their financial security.

10. Please summarize the findings of The Access Project's report on the Massachusetts Student Health Insurance Mandate.

Massachusetts health reform passed in 2006 included a provision that residents of the state must have health insurance coverage. This individual mandate has been lauded as innovative, although the state actually implemented an individual mandate once before. Nearly 20 years earlier, in 1988, Massachusetts passed what was commonly referred to as the Dukakis Universal Health Care Law. The law included a requirement that all students enrolled at least three-quarters time in an institution of higher learning in the state have health insurance. This "student mandate" has been in effect since that time.

The regulations governing the student plans state, in non-specific language, the minimum benefits that a plan must include to qualify as coverage under the program. They include requirements that a plan provide "reasonably comprehensive coverage," including preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services and mental health services. Though the regulations called for reasonably comprehensive coverage, our research identified a number of problems with the plans. They included the following:

Coverage Caps: Nine out of ten plans included caps of $50,000 or less on the amount to be paid per illness or injury. The plans also included caps on particular services. Examples include a $5,000 cap on surgeons' fees, a $1,500 cap on outpatient care, and a $150 cap on ambulance services. Some plans also had caps for other high-cost procedures, such as CAT scans, MRIs, radiation, and chemotherapy.

Co-insurance: Co-insurance was a common component in the student plans. The amount students were responsible for paying ranged from 20 to 70 percent of costs. The co-insurance was in addition to any deductible and co-payments that patients may have paid when they received care.

No limits on out-of-pocket costs: Very few of the plans set maximum amounts that policyholders would be required to pay in out-of-pocket expenses. In the few instances where there were limits, the maximums applied only to co-insurance paid during the plan year.

Complexity: In addition to deductibles, co-insurance, co-payments, and other fees, we found that the complexity of the cost-sharing arrangements in the plans left students with significant out-of-pocket costs. This sometimes occurred even when they received services that the plans should have covered.

The experience with the student mandate makes clear that insurance coverage in and of itself does not guarantee people access to care or protection from serious financial loss. Nor can one judge the affordability of insurance simply in terms of the amount of the premium. These student plans generally have low premiums and low deductibles. However, the co-payments, co-insurance, and particularly the illness, injury, and benefit caps serve as barriers to accessing care and leave students exposed to excessive financial costs.

We recommended in our report that the state must hold insurance companies accountable for the quality of their products and services, especially when mandating that people purchase insurance. The Access Project believes that it is crucial to enact and enforce strong consumer protection mechanisms in the health insurance marketplace.

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ANSWERS TO POST-HEARING QUESTIONS FROM DAVID U. HIMMELSTEIN, HARVARD MEDICAL SCHOOL, CAMBRIDGE, MA

Response of David U. Himmelstein, M.D.
To Questions from the Committee on the Judiciary, Subcommittee on Commercial and Administrative Law

1- Full resolution of the medical debt and medical bankruptcy problems will require fundamental reform of our health care financing system, coupled with improvements in disability insurance coverage. Only national health insurance assuring first-dollar coverage of all medically necessary care can offer full protection from medical bills. Employment-based coverage is bound to fail, since many individuals become too sick to work, and hence lose their employment-based insurance exactly when they need it most. Policies that carry deductibles, copayments, limitations on coverage or exclusions also leave Americans vulnerable to medical bills at the time in their lives when their incomes are at likely to fall due to illness. In sum, health coverage should be comprehensive and fully guaranteed regardless of ability to pay or employment status, and without out-of-pocket costs.

But even comprehensive health insurance coverage would leave some Americans vulnerable to financial catastrophe due to illness because many lose income when they are sick. Hence, improvements in disability coverage are an important adjunct to health reform in assuring the financial well-being of American families. Such coverage should guarantee continuation of income in the face of illness, and provide for income replacement for parents or others who have to take time off from work to care for a sick child or other relative.

In the short term, Congress should reverse the disastrous changes in bankruptcy laws enacted in 2005. These changes denied protection to many families bankrupted by illness or medical bills, leaving them at the mercy of the rapacious credit card industry.

2- As indicated above, passage of a universal, comprehensive national health insurance program would alleviate the majority of medical debt problems and medical bankruptcies. H.R. 676 would construct such a program, assuring full coverage for all medically necessary care for every American. Americans would no longer face out-of-pocket medical bills.

3- I believe that a prohibition on reporting medical debts to credit agencies and others responsible for assessing credit scores would have a modest positive impact. At present, some Americans are reticent in seeking care because they fear

that medical debts will compromise their creditworthiness. Others avoid care because past debts have led to credit problems. Alleviating these credit fears would likely lead some to be more likely to seek care when they need it.

4- As far as I am aware, the only formal study examining medical bankruptcy in a nation other than the U.S. was based on Canadian data. This study found a low rate of medical bankruptcy in that nation. Informal conversations with health policy experts in Switzerland, Sweden, France and the U.K. leads me to believe that medical bankruptcy is rare in those nations.

5- I would respond to Professor Zywicki's statement in several ways.

   a. Doctors currently enjoy quite high incomes – about $200,000 annually on average – and most hospitals, imaging facilities, outpatient surgery centers etc. are quite profitable. With the exception of safety-net hospitals and clinics, there is little evidence of widespread financial distress among health care providers, and little reason to believe that they are suffering in any substantial way from unpaid medical debts, or that quality of care is in any way affected by lack of adequate funding.
   b. The billing apparatus required to secure payment and pursue medical debtors under the current health care financing system is extraordinarily expensive and wasteful, and is obnoxious to many physicians, nurses and other health personnel. It requires vast amount of physicians' time, distracts health institutions from their mission of care, and poisons the doctor-patient and nurse-patient relationship.
   c. A comprehensive, single payer national health insurance program such as that proposed under H.R. 676 would assure doctors and health care institutions of full payment, eliminate the noxious aspects of billing, save money on bureaucracy, and also virtually eliminate the problems of medical debt.

6- I am not aware of reliable data on expenditures by health care providers on medical debt collection. Studies by my colleagues and I have documented that approximately 31% of total health spending in the U.S. is devoted to administrative tasks, and that a single payer national health insurance program could eliminate about one half of that spending.

7- It is hard to know whether hospitals or clinics are using federal funds to pursue medical debtors because these funds are not readily distinguishable from other sources of funding. It is certainly true that hospitals and other medical providers that receive federal funds spend money pursuing medical debtors, and the costs of such debt collection efforts are not generally segregated in such a way as to assure that federal funds are not used.

8- I am not familiar with data on the number of medical debt collection firms, or the number of such firms hired by medical providers.

9- According to survey data from the Commonwealth fund, 13% of Americans aged 19-64 have received a call from a collection within the past year regarding a medical debt. This estimate is in line with the results of a Kaiser Foundation survey in 2002 which found that 12% of adults over 18 reported being contacted by a collection agency regarding a medical bill within the past year; 21% reported problems paying a medical bill.

10- Extrapolating from the survey data cited above, it seems likely that approximately 12% of adults – about 600,000 people - in Massachusetts receive a collection call regarding medical debt annually. It is unclear what share of these calls are regarding hospital bills vs. bills from other medical providers. If we assume that half are regarding hospital bills, then each of the roughly 80 hospitals in my state generates collection calls to about 4000 people annually.

11- I am unaware of the profit margins of debt collection firms.

12- Other than the Commonwealth Fund and Kaiser Foundation survey data cited above, I am not aware of data on how many Americans with medical debt have that debt reported to debt collection agencies.

13- Again based on Commonwealth Fund and Kaiser Foundation data, it seems likely that approximately 12% to 13% of Americans have current medical debts, that is debts for which collection calls are still being made. It seems likely, that a much larger fraction of Americans have had medical debts reported to a collection agency at some point in the past.

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