S. HRG. 111–425

MEDICAL DEBT: CAN BANKRUPTCY REFORM FACILITATE A FRESH START?

HEARING

BEFORE THE

SUBCOMMITTEE ON ADMINISTRATIVE OVERSIGHT AND THE COURTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

OCTOBER 20, 2009

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U.S. GOVERNMENT PRINTING OFFICE

56–473 PDF WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MEDICAL DEBT: CAN BANKRUPTCY REFORM FACILITATE A FRESH START?

THURSDAY, OCTOBER 20, 2009

U.S. SENATE,
SUBCOMMITTEE ON ADMINISTRATIVE
OVERSIGHT AND THE COURTS
COMMITTEE ON THE JUDICIARY,
Washington, DC

The Committee met, pursuant to notice, at 10:03 a.m., Room SD–226, Dirksen Senate Office Building, Hon. Sheldon Whitehouse, Chairman of the Subcommittee, presiding.

Present: Senators Feingold, Franken and Sessions.

OPENING STATEMENT OF HON. SHELDON WHITEHOUSE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Chairman WHITEHOUSE. Thank you all very much for being here. I want to thank the Ranking Member, Senator Sessions of Alabama, for being here. I see my colleague from Minnesota, Senator Franken, delighted that he is here.

As we in Congress continue working on broad legislation to reform our broken health care system and ensure accessible, affordable health insurance for all Americans, we take advantage of this hearing today to examine a particularly cruel effect of our current system—the millions of Americans drowning in medical debt.

As health care costs continue to increase, so do the number of people who go bankrupt paying essential medical bills for themselves or their loved ones.

Harvard University researchers recently estimated that medical debts are a driving force in over 60 percent of personal bankruptcy filings. Three-quarters of the medical debtors in that study were covered by medical insurance. They acted responsibly and thought they were covered, but were bankrupted by copays, deductibles, premiums, coverage limits, and uncovered expenses.

Families who think they are protected may be only one accident, one injury or one diagnosis away from family bankruptcy. Unfortunately, the bankruptcy code does not distinguish between debtors driven into bankruptcy by medical bills and those who become insolvent through poor planning or reckless spending. The Medical Bankruptcy Fairness Act would change that.

If enacted, this bill would waive procedural hurdles for filers with high levels of medical debt. It would waive the means test and credit counseling requirements, which are unnecessary, time-consuming, costly, even humiliating for debtors forced to file by medical misfortune.

In addition, my bill would help make it easier for medical debtors to retain their homes in bankruptcy by providing an alternative homestead exemption of $250,000. The default homestead exemption is determined by state law and varies across the country.

While debtors in my home State of Rhode Island already receive a relatively generous exemption, debtors in the Ranking Member's home State of Alabama get to preserve only $5,000 of home value through the bankruptcy process.

The Medical Bankruptcy Fairness Act would give medical debtors across the country a fighting chance to save their homes.

Finally, too many debtors find themselves unable to file cases for a discharge of their debts in a Chapter 7 bankruptcy. My bill would make pre-petition attorney's fees non-dishargeable in bankruptcy.

This will give debtors the option of paying their attorney's fees when they are on firmer budgetary ground after completing the bankruptcy, in turn, making less expensive Chapter 7 proceedings more viable.

I look forward to hearing the views of today's panel on this proposal and others. Kerry Burns, a constituent of mine from Coventry, Rhode Island, will share the story of the loss of her young son, Finnegan, to cystic fibrosis. Even though she had health insurance, the costs of her son's illness ultimately forced her to walk away from her mortgage and declare bankruptcy. She is accompanied here at the hearing today by her husband, Patrick.

Elizabeth Edwards works on health care issues as a senior fellow at the Center for American Progress in Washington, DC. Ms. Edwards has long advocated for health care reform both as an attorney and on the campaign trail with her husband. Ms. Edwards holds a J.D. from the University of North Carolina and has had a distinguished career as an attorney working for the North Carolina Attorney General and in private practice. We welcome her.

Professor John Pottow is a tenured professor at the University of Michigan Law School, where he specializes in bankruptcy and commercial law. Following law school at Harvard, Professor Pottow clerked for Hon. Guido Calabresi on the Second Circuit Court of Appeals and the Right Honorable Beverley McLachlin on the Supreme Court of Canada. His extensive scholarship includes work on bankruptcy reform and consumer lending.

Aparna Mathur is a research fellow at the American Enterprise Institute, where she has done work on tax and economic policy. Dr. Mathur holds a Ph.D. from the University of Maryland, where she served both as teaching assistant and instructor in economics. She has also worked as a consultant to the World Bank.

Our final witness, Diana Furchtgott-Roth, is the Director of the Center for Employment at the Hudson Institute, a think tank in Washington. Prior to joining Hudson, Ms. Furchtgott-Roth was chief economist at the U.S. Department of Labor. From 2001–2002, she served as chief of staff at the President's Council of Economic Advisers. She received her bachelor's degree from Swarthmore College and holds a master's degree in economics from Oxford University.

I welcome the witnesses and I call on the Ranking Member for his opening statement.

[The prepared statement of Chairman Whitehouse appears as a submission for the record.]

STATEMENT OF HON. JEFF SESSIONS, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator SESSIONS. Thank you. Bankruptcy is referenced in the Constitution and it is one of the great things that I think our legal system provides. So if a person is too deeply in debt, they can wipe out those debts and start over again.

That has been a classical American principle since our founding. In recent years, more and more people are aware of those possibilities and more and more filings are made, but less than 1 percent of our people do file bankruptcy on a yearly basis.

I would just say that I have never understood and do not agree that the means test is any kind of punishment. The means test is designed so that if an individual makes at or below the median income of the state in which they live, they can file and wipe out all their debts under Chapter 7, as they always have been able to do.

But if they make above median income and a judge finds that they are able to pay back some of their debts, they should be required to do so. That was the whole intellectual basis of the bankruptcy bill that we passed.

Professor Todd Zywicki noted in an article this, quote, "Roughly 80 percent of bankruptcy filers earn below median state income and so will get tossed out of the means test immediately. For that 80 percent, roughly 1.2 million of the 1.5 million filers in 2004, the means test will be completely irrelevant. They will be permitted to file Chapter 7."

So there was a real concern in our country that people living in mansions were able to bankrupt and not pay their hospital and doctors. People who had high incomes, doctors and lawyers and other people, were bankrupting against debts when they could easily have paid at least a portion of their debts.

So that was the intellectual basis of the discussion that we entered into over a period of years and resulted in 83, I believe, Senators voting for the bankruptcy reform bill, over 80, and I think it is defensible and correct.

Now, there is a concern about health care and I understand that and I respect that. First, we need to get what the true facts are. I know one of the studies Professor Warren did included gambling as a health care matter, debts and other things that may or may not normally be considered and the numbers I do not think stand up to be quite as high as some people suggest.

But if a person has extraordinary medical bills and is unable to work, they would clearly qualify for the Chapter 7 and wipe out all their debts and in no way be obligated to file under Chapter 13 and pay back a certain portion of them.

But if they do have high incomes, why should they not pay their hospital? If somebody else has got high bills because of gambling debts or other things, they have to file under Chapter 13. So I just would think that you would want to pay back the debts if you could, if a person could.

Remember, a judge would not require an individual to pay back all, just that amount that the court finds they are able to pay back

and if their income is below the poverty level, which is about $44,000 for a family of four, then they would not, under any case.

Also, a debtor can still avoid paying back any debts under the means test by showing special circumstances, and a serious medical condition is a circumstance. Even if a person is able to work and has a higher income, if they have higher expenses or uncertainty of that income because of a medical condition, that can be a special circumstance. A judge can allow them not to have to pay back any of that money they might owe.

So I am looking forward to the hearing. Ms. Edwards, it is good to see you and good to have you with us particularly and all of the panelists. I would just say this—that I am open to the concerns, but I do not believe that we should start reversing the means test, which I absolutely believe is a healthy thing and I would urge my colleagues to think carefully about that.

Certainly, from our last votes we had in the Senate, most people, after a number of years of discussion and debate, concluded that people who make above median income, who are able to pay back some of their debts should pay them back.

If you are in poverty, if you have lost your job, you have great medical debts, you can wipe those out, as always has been done.

Thank you, Mr. Chairman.

Chairman WHITEHOUSE. You are very welcome and I thank the Ranking Member for his statement. It is not unusual for the Ranking Member and I to take different points of view on issues, but on more than one occasion, we have already found ways to come together and agree on legislation and I hope that as this goes forward, this will prove to be one of those areas.

If I could ask the witnesses, please, to stand and be sworn.

[Witnesses sworn.]

Chairman WHITEHOUSE. As I said, our first witness will be Kerry Burns, who comes to us from Rhode Island. Ms. Burns, thank you. I am very grateful that you are here and I very much appreciate that Patrick came down with you. Please proceed.

STATEMENT OF KERRY BURNS, COVENTRY, RHODE ISLAND

Ms. BURNS. Chairman Whitehouse, Ranking Member Sessions and members of the Committee, thank you for the opportunity to participate in today's hearing. My name is Kerry Burns and I am from Coventry, Rhode Island.

I am here to tell the story of my family's medical debt. My story starts in 2004 with the birth of my son, Finnegan. A day after Finnegan's birth, he was diagnosed with cystic fibrosis, something that shocked and devastated me and husband, Patrick.

Finnegan was a fighter from the start. After some initial difficulties, he thrived in all areas. He was a bright, funny, caring and loving little boy who was the light of our lives.

Finnegan was hospitalized in intensive care for 13 months before he passed away this March at the age of 4.5 years old. In February 2008, Finnegan became sick with what we thought was just a common cold. After several days of vomiting and simply not feeling well, Finn's doctors suggested we bring him to the hospital to see if he was dehydrated.

When we brought Finn to the emergency room, the doctors ascertained that he had a major bowel obstruction, which required surgery. The night of the surgery, Finn went into cardiac arrest and we were told by the surgeon that Finn would likely not survive the necessary emergency surgery.

But Finnegan did survive that surgery. He had 6 surgeries in his first 9 days in the hospital and survived countless others. He was intubated for almost 2 months and then received a tracheotomy. Finn was in very rough shape, but slowly and amazingly, his condition began to improve. He showed a fierce spirit and will to live.

Finnegan spent a total of 8 months at Hasbro Hospital in Providence, Rhode Island. We were then sent to Yale University for transplant evaluation. It was determined that Finnegan would require a multi-organ transplant and we were transferred to Georgetown University Hospital here in Washington.

My husband and I stayed right by our son's side during every step of his fight. To do this, we both had to take leave from our jobs. We could not, however, have anticipated how long Finn's treatment would last or the ultimate ramifications of our decision to be with him.

During this period, we had only temporary disability income and unemployment benefits, which were far less than we had earned before. We struggled to pay our monthly bills, including our mortgage. As our money dwindled and the bills began to pile up, we did everything we could to keep our heads above water, including cashing in our retirement funds and selling belongings for extra money.

Once we were sent to Georgetown for care, we sold our second car. Family and friends were gracious and generous enough to donate money to help us.

Eventually, the bills piled up beyond our ability to pay them. We were forced to default and, despite our circumstances, creditors were unwilling and/or unable to help us. They wanted money and we simply had none to give.

The collection calls were unrelenting, upwards of 30 calls to each of our cell phones every day, all while we were in an intensive care unit willing our son back to health.

As Finn's hospitalization stretched from weeks to months, we had to make difficult decisions about which bills to pay. The top priority was retaining ownership of our home and I am proud to say that we were able to make our mortgage payments through 10 months of Finn's hospitalization. Unfortunately, starting this past January, we were no longer able to make those mortgage payments.

The emotional hardship my husband and I endured over the course of our son's hospitalization pales in comparison to what we have felt since his loss. Losing a child is the greatest injury for a parent and something we would not wish on anyone.

As if this loss were not enough to handle and rebuilding our lives without our son was not hard enough, we have been faced with financial ruin. When people hear our story and our financial problems, it is often assumed that we did not have medical insurance to cover Finn's expenses.

We did have insurance and the vast majority of Finn's treatments, totaling nearly $5 million, were covered. We were lucky

enough that my husband's former employer covered our insurance for several months. After that, we had to pay extensive COBRA fees to maintain our insurance until being approved for state-sponsored health care.

Our return to Rhode Island from Washington was difficult for many reasons. First and foremost, we came home without the most important person in our lives. We had so little money left that I was selling belongings on eBay to get gas money and toll money to return home.

Back in Rhode Island, we did not return to live in our house, unsure of when the foreclosure process would actually take it. Instead, we lived with friends. We had difficulty renting an apartment because our credit had been ruined. In order for both my husband and I to return to work, we need two cars. We have only one and will not be able, for some time in the future, to obtain the second.

I had no prior knowledge about how one would file bankruptcy and certainly never thought I would be in the position to have to do so. I have found that it is a demeaning and demoralizing process, one that my husband and I are in through no fault of our own. We simply made the right choice as parents to be with our son in his greatest time of need.

In order to file bankruptcy, we needed a $250 retainer and a $1,300 filing fee. We actually had to borrow the money in order to officially go bankrupt. As if this were not enough, a credit counseling class is required both before and after the filing, with fees in addition to those of the filing.

My husband and I sat down to take this class online and were surprised by the tone of the questions, which seemed quite insulting and which included those about why we were going bankrupt and how we could have avoided the situation in which we currently find ourselves. In addition, the course required us to recalculate and resubmit the financial information already submitted to our lawyer.

I believe the Medical Bankruptcy Fairness Act, introduced by Chairman Whitehouse, would help families like mine recover from medically-based financial hardship. As I understand it, it would waive some of the procedural hurdles to bankruptcy relief, including the humiliating credit counseling requirement. The bankruptcy system needs to be modified to take into account how people actually come into bankruptcy.

I have worked since the age of 14. I have a master's degree and have spent my professional social work career helping others. To be unable to help myself and my husband financially and for not being able to save my son is embarrassing and shaming and truly adds insult to injury. It is my hope that by sharing our story, changes can be made to the system to help others in a similar situation in the future.

Thank you.

[The prepared statement of Ms. Burns appears as a submission for the record.]

Chairman WHITEHOUSE. Thank you, Ms. Burns.

Ms. Edwards.

STATEMENT OF ELIZABETH EDWARDS, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS

Ms. EDWARDS. Thank you, Chairman Whitehouse, Ranking Member Sessions and members of the Committee, for inviting me to be here. I have to say that speaking after Ms. Burns is difficult because she is exactly the reason that I think this bill is important, I am certain one of the reasons you had in mind drafting it.

We are in the middle of a national debate on health care, which would address some of the issues that might have been faced by the Burns family. For the first time in 15 years, we are actually trying to fix a broken health care system and deal with the twin problems of the status quo, which are skyrocketing health care costs, and millions of Americans living without health care coverage.

One of these problems is the problem that trapped the Burns family, which is the skyrocketing health care costs and, of course, probably a degree of under-insurance, as well.

I know the Committee is particularly interested in the financial hardships that many Americans experience due to health care costs. People with poor or no health insurance coverage in a significant health problem are particularly likely to accrue considerable medical debt and, therefore, those exactly are the people who are most vulnerable to bankruptcy.

Medical debt, of course, is a symptom of a larger problem in our health care system that we hope to solve, but the problem of affordability is most apparent for the nearly 47 million Americans who lack health insurance. Roughly two-thirds of Americans without health insurance have incomes below 200 percent of our Federal poverty level, as Chairman Sessions was saying, approximately $44,000 for a family of four.

Most people without health insurance are workers or they live in families with someone who works, but they do not have health coverage through their employer. With the annual average cost of employer-sponsored health insurance exceeding $13,000 a year, health insurance is clearly unaffordable for families and many small businesses, but certainly unaffordable for families who then are forced to purchase it on their own—and they are not going to get it for $13,000 a year.

Without robust health care reform, the cost of health care insurance, if it proceeds at the current pace that we have seen in the last decade, could exceed $30,000—compare that to the $44,000 that we just talked about—$30,000 at the end of the next decade. We have not seen and we are unlikely to see any wage increases in that realm.

Sadly, people who actually have health insurance have become increasingly vulnerable to problems associated with paying for health care. A recent analysis by the Commonwealth Fund identified 25 million Americans, adults, these are just the adults, who have health insurance, but are under-insured. This represents an unbelievable 60 percent increase from 2003.

Another study found that one in five Americans reported problems in paying medical bills in 2007. Even moderate levels of out-of-pocket spending relative to family income created medical bill problems.

I sit in a chemotherapy chair once every few weeks and listen to people speaking with the person that accompanied them, wondering how they are going to pay for the kinds of care that they need in order to stay alive.

Financial problems are a major hazard of under-insurance and un-insurance and of sicker adults, three-fifths reported they had been contacted by a collection agency. Three-fifths of people who are sick have been contacted by a collection agency.

In a 2000 survey, respondents reported making difficult choices between using up a lifetime of savings and their retirement funds, as the Burns chose to do, running up credit card debt skipping the purchase of other necessities, adding a mortgage against their home in order to pay medical bills. It is actually one of the reasons that debts sometimes get hidden in other ways.

The special circumstances for existing debt to which Senator Sessions was referring is often masked by the fact that people have tried for a long time to stave off bankruptcy and that medical debt is hidden in other forms, as was the situation with the Burns, where the lack of a safety net with which they provided themselves was caused by a long-term illness.

So many medical debtors turn to borrowing to cover accrued medical expenses in order to continue treatment. In some cases, bankruptcy may be driven not by under-insurance, but by bad company practices and those who suffer wrongful rescission or denial not only include the debtor, they are harmed, but also harmed are the other creditors, because you are forced into bankruptcy.

They are going to end up taking only a portion of what they might have gotten had the rescission or denial not occurred.

Your proposal, Mr. Chairman, the Medical Bankruptcy Fairness Act would help medical debtors by providing them easier access to Chapter 7 discharge and enabling them to retain at least $250,000 in home value and assets. It would exempt them from burdensome credit counseling requirements.

Honestly, what are they going to tell the Burns, "Don't get sick? Don't let your son get sick?" I mean, that is the credit counseling advice that would have been actually applicable to them. The rest of it was clearly not going to be.

There are interim steps that you may want to consider, as well, to solving problems specific to medical bankruptcy. I will tell you that I practiced bankruptcy law for about a decade and so though I do not have the expertise of Professor Pottow, I do have some practical experience in the courtroom with the problems that are discussed here today.

It is true, though, that the problem is simply an issue associated with our failing to address adequately and I hope that we will be addressing the health care insurance problems that exist in this country.

Thank you so much for your time.

[The prepared statement of Ms. Edwards appears as a submission for the record.]

Chairman WHITEHOUSE. Thank you so much, Ms. Edwards.

Professor Pottow.

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STATEMENT OF JOHN A. E. POTTOW, PROFESSOR OF LAW, UNIVERSITY OF MICHIGAN LAW SCHOOL, ANN ARBOR, MICHIGAN

Mr. POTTOW. I thank you very much. Probably practical experience is better in this regard than economic experience. So I will defer to Ms. Edwards and counsel you to take her advice with greater weight than mine.

I am going to talk a little bit in what is going to be an anticipatorily defensive posture regarding what I am sure you have been considering about the so-called Harvard study on medical bankruptcies, and I say this as one of the co-investigators on that research project. I did not publish specifically on that medical study, but I did use that data and I was involved in literally a year's long process on scrubbing the methodological protocols to ensure that the data were as reliable as possible. And so I feel somewhat invested in speaking to some of the concerns that have been made regarding this data.

There are small things made back and forth. Mr. Sessions mentioned the point about the gambling addictions that were included. That was an earlier study when they decided—when the physicians said we should use certain things that are coded as addictions or disorder by the psychiatrists or—I start to glaze over between psychiatric and psychological.

But the point is that there are certain medical conditions that are classified as addictions and compulsions. So that was put in the broader definition of medical bankruptcies. And the researchers were very specific breaking out—they said this is when we are using the broad definition that includes things like medical addictions and this is the narrow definition when we are just taking medical bills and this is the definition when we are just asking people whether they are doing bankruptcy or not.

In the subsequent study, they said let's just drop the addiction stuff, because it does not make that much difference to the numbers and it is just distracting people.

So I want to dispel the suggestion that they were trolling for things that could simply inflate their numbers and picking willy-nilly loose descriptions of what could be a medical bankruptcy.

I think something that is terribly important about the study and any studies that purport to assess the incidence of medical bankruptcies and what is unique and methodologically commendable about the current study is that it disaggregates—sorry, strike that. It does not try to separately classify medical debts as a separate species from credit card debts or other forms, because as we have learned through field research—I have actually done qualitative interviews and talking to attorneys and debtors and people who have gone through the bankruptcy system—you cannot simply say this is a medical debt and separate that from a credit card debt, because lo and behold, in this economy, people pay medical expenses with credit cards.

So if you just try to abstract court records, if you take court records and read the names of the creditors on the bankruptcy petitions, you see names like Capital One. Well, you do not know what that is. That could be a—I mean, it is a credit card debt, but you do not know what the underlying cause of the expenditure was.

If you see something that says Providence Health Care, you can figure that is a medical debt. So some studies say, "Oh, that is a medical debt."

But unless you go in and interview the debtors and ask them, "What were you spending your money on, what were you doing?" you cannot get a full understanding of what is going on in this area.

So the Harvard study has supplemented the court records data. Other researchers have looked at the court records, read the files, and they actually conducted questionnaires: people filled out questionnaires, and said, "Why did you go bankrupt? What were the causes? List the causes of what you were doing."

And they supplemented it with a subset of that questionnaire group, conducting telephone interviews, where they spent over an hour talking on the phone to them. So it is a very rich, comprehensive understanding of people using the bankruptcy system.

It is a random sample. Bias checks were done to make sure the people who answered the phone interviews were not disproportionate from the people answering the questionnaires. All sorts of bias checks were conducted on this area.

What I find commendable, also, about the investigators in that area is when their 2001—I call it the 2001 study, because the data came out in 2001 and it was published a few years later.

When the 2001 data came out, people said, "Well, why don't you try a more stringent definition of medical bankruptcy?" They had used $1,000 of out-of-pocket unreimbursed expenses. And so they said fine. So they went back and they said, "We'll still do the $1,000 so we can compare apples to apples to see if there has been a change using the same measurement in 2007." There was. The number had gone up in medical bankruptcies by about 40-odd percent, if not more, in a small period.

And then they tried a more stringent definition and said, "What if it is over $5,000 in medical debts?" and it dropped the numbers, but the drop in the numbers was like from 67 percent to 62 percent. It statistically is not making that much of a difference based on the stringency of your definition.

So we can sit here and debate until the cows come home whether it is 60 percent or whether it is 40 percent, but the point is we have a substantial incidence of medically related bankruptcies. We can find this from the survey evidence gathered. You can find this from the qualitative evidence when you go talk to attorneys who actually practice in the field and deal with people and deal with people like Ms. Burns and you get to say to them "Why are you people going bankrupt?"

Credit cards come up all the time and then medical bankruptcies is always up there. No one will say it is the only cause. I do not think any attorney would say it is all medical bankruptcies, there is nothing else in there, but the corollary of that is I do not think you would find any consumer bankruptcy attorney who would not say medical causes—medical bankruptcies are a big chunk of it up there.

That is my assessment. I have been doing this for a few years now and I have been doing a lot of research with attorneys and to question the prevalence of medical bankruptcies seems to me al-

most like preemptively closed-minded or fundamentally immune to considering what the data present.

I have exhausted my time. I will reserve the rest for questions.

[The prepared statement of Mr. Pottow appears as a submission for the record.]

Chairman WHITEHOUSE. Thank you, Professor.

Ms. Mathur.

STATEMENT OF APARNA MATHUR, RESEARCH FELLOW, AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH

Ms. MATHUR. Chairman Whitehouse, Ranking Member Sessions, and distinguished members, thank you for inviting me to testify before the Committee today. Before I begin, I would just like to say to Kerry and Patrick, I am really sorry about your loss. I cannot imagine what it felt like going through that.

In my testimony, I will explore provisions of the Medical Bankruptcy Fairness Act that may help or hinder the efficient functioning of the bankruptcy system. The act would allow debtors with a certain level of medical debt to file for Chapter 7 bankruptcy with no means testing requirements, a high home exemption limit, and the ability to discharge not just medical debts, but also all other debts, such as high credit card debts.

While I believe that the sentiments governing the act are understandable and I am completely sympathetic to the plight of families undergoing medical distress, during the course of my testimony, I will attempt to show that the provisions of the act may be open to abuse and fraud.

This could have unintended adverse consequences for debtors that may worsen rather than improve the functioning of the bankruptcy system for exactly the people that it is intended to help.

The urgency to tackle the issue of medical bankruptcies is being largely driven by studies claiming that more 60 percent of all personal bankruptcy filings are caused by medical debt.

How valid is this supposition? The most extensive nationally representative data on medical debts is available from the Survey of Consumer Finances. A look at the latest data shows that medical indebtedness has not changed significantly over the past decade.

The SCF includes medical debts with other debts incurred for goods and services, including credit card debt and, indeed, some of these debts have risen marginally from 5.5 percent for all debt in 2001 to 5.8 percent in 2007.

Therefore, even if all goods and services debts were simply medical debts, the rise has been less than half a percentage point. The idea that medical bankruptcies are on the rise comes essentially from two studies done by Himmelstein, Warren and other coauthors. In the appendix of my longer written testimony, I discuss methodological problems with these surveys. However, I will talk about a couple of issues here.

As John Pottow pointed out, table 2 of the 2009 study clearly states that only 29 percent of the respondents believed that the bankruptcy was actually caused by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than

$5,000 in medical bills, and the percent of people reporting any medical problems.

This is clearly an overstatement of the problem, since the people do not themselves believe that this was the cause of the medical bankruptcy.

Second, what the authors have established is some correlation of medical debts and bankruptcies, but not causation, and that is an inherent problem with all survey data. In fact, more rigorous analysis using standard regression techniques to establish causation finds little effect of medical debts on bankruptcies.

This economics literature is discussed in my longer written testimony and based on this, I find that the foundations of the Medical Bankruptcy Fairness Act are built on somewhat shaky grounds, even though I acknowledge the idea in principle.

Further, the act will reform the current bankruptcy system in ways that could have unintended adverse consequences. First, the act defines a medically distressed debtor as a debtor who has medical debts in excess of 10 percent of household income.

A study of the distribution of bankruptcy filers by income in 2000 to 2002 showed that more than 85 percent of filers had annual incomes less than or equal to $48,000, with almost 60 percent earning between $24,000 to $36,000.

This means that if the average filer spent about $2,400 to $4,000 on medical care in any year, then they would qualify for a medical bankruptcy. The same study shows that credit card debts average approximately $20,000 for this group of low income borrowers.

In the worst case scenario, this could create a perverse incentive for households since by accumulating a relatively lower level of medical debt, they could take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of the high credit card debts.

Therefore, by allowing debtors to file as medical debtors, irrespective of whether medical debts are actually driving the household to bankruptcy, the act could impose huge costs on the system.

Second, the act would remove the means testing requirement from medically distressed debtors. Doing away with the means test under the act would allow high income individuals to walk away from not only their medical debts, but also other debts, such as credit card debts.

In the study of bankruptcy filers cited earlier, those with incomes higher than $70,000 had average credit card debts of $42,000. Allowing this group to take advantage of the debt discharge provisions under Chapter 7 would hit creditors particularly hard.

Third, it would allow these distressed individuals to claim an exemption against the home of $250,000, essentially overriding any state exemption limits. However, high exemptions for wealth and income make filing for bankruptcy more attractive and studies show that the number of filings increase when exemptions increase.

This adversely affects the market for credit. To insure against the probability for bankruptcy filing, lenders raise interest rates or ration credit, which harms debtors who repay, as well as those who would like to borrow, but are rejected. Hence, creditors alter behav-

ior when faced with higher exemptions and this could have adverse consequences for debtors.

Finally, the act does little for creditors in these medical transactions. As discussed in the previous paragraphs, there could be potentially serious consequences for medical service providers if you make it easier for debtors to file for medical bankruptcy involving the discharge of all medical debts.

In fact, research has shown that between 1994 and 2000, unsecured creditors received nothing in about 96 percent of Chapter 7 bankruptcy filings and in most Chapter 13 cases, only mortgage creditors received anything at all.

These higher costs of bad debts will ultimately be passed on to consumers in the form of higher prices for care or poor delivery of care.

To conclude, I believe that any situation that causes a household to file for bankruptcy is unfortunate. In these tough economic times, individuals who lose their job for no fault of theirs are as badly affected as families hit by illnesses or injuries.

Individuals who lose their homes because of a painful divorce are no worse off than people who are unable to pay their mortgages due to an unexpected change in credit conditions.

Where do we draw the line for who we want to help and who we do not? The most effective solution to the problem of rising bankruptcies is to create the right conditions for an economic recovery so that families can hold onto their jobs, retain their earning power, stay in their homes and live within their means. We should help them to avoid bankruptcy rather than make it easier to file it.

Thank you.

[The prepared statement of Ms. Mathur appears as a submission for the record.]

Chairman WHITEHOUSE. Ms. Furchtgott-Roth.

STATEMENT OF DIANA FURCHTGOTT-ROTH, SENIOR FELLOW, HUDSON INSTITUTE

Ms. FURCHTGOTT-ROTH. Mr. Chairman, Mr. Sessions, thank you very much for inviting me to testify here today. With your permission, I would like to submit my written testimony for the record.

Chairman WHITEHOUSE. Without objection.

Ms. FURCHTGOTT-ROTH. Thank you. I would first like to extend my sympathies to Kerry and to Patrick. I have six children myself. I cannot imagine what it would be like losing one of them. It must just be the worst thing in the world and I want to tell you that my sympathies are completely with you.

The discussion of the merits of the Himmelstein study, I think, has been effectively gone over by Ms. Mathur and discussed already and I guess what I would like to talk about is what to do about the health system in general, because it seems like the problems of medical bankruptcy are being used in order to say that we need health reform.

And it is very true that we do need health reform. It is easy to get auto insurance. It is easy to get home insurance. It is easy to get life insurance. What is really difficult is to get health insurance.

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The bills under consideration now in Congress—the two bills in the Senate, the bill in the House—would make the situation worse and those, in fact, would exacerbate the problems of bankruptcy in the United States, not just medical bankruptcy, but bankruptcy overall. This is because these bills would result in a worse economic situation, loss of jobs.

Here is why. Everyone would pay more for health insurance under aspects of the plans under consideration. The premiums would rise. There would be a 40 percent excise tax on high premiums.

The Congressional Budget Office estimates that Americans would pay $100 million more in premiums. Large comprehensive plans would be required for everybody including catastrophic health plans, the kind of plan where you can pay for routine costs out of pocket, just like you pay for changing your oil with a car or changing your windshield wiper blades. Auto insurance does not pay for that, and health insurance should not pay for routine care either.

What is important is to have insurance to safeguard against large medical happenings, such as what happened with Kerry and what happened with Ms. Edwards. What is important is for large insurance against these—getting in a car accident, cystic fibrosis, getting cancer. Those catastrophic health plans would actually be disallowed, because you could not purchase them through the health exchange.

The high cost of the health insurance plans would lower cash wages. Fewer workers would be employed. There would be more part-time workers and jobs would be outsourced. This would especially affect workers near the minimum wage. And if you lose your job, you are at a greater risk of bankruptcy.

There would be funds cut from Medicare and Medicaid. The Baucus bill, for example, mandates $404 billion in cuts over 10 years from Medicare. That would result in a lower quality of care. If you have a lower quality of care, you are more likely to be sick, and stay sick longer.

Tax increases would discourage job creation. Under the House bill, the top tax rate would go up to 45 percent. That is on our most productive businesses. And it is not just tax rates at the top. At the low end, the Congressional Budget Office has estimated that people at 150 percent of the poverty line would face a tax rate of 59 percent as the different health affordable credits phase out.

Employers would face a payroll tax of 8 percent if they did not provide the right kind of health insurance. We have a 9.8 percent unemployment rate right now; 15 million Americans are uninsured. Our teenage unemployment rate is 26 percent. The last thing we need is an 8 percent tax on employer payrolls that would further discourage job creation.

The only group that these bills would help would be foreign workers, because with the high cost of labor, the much higher cost, employers would be encouraged to open their next plant offshore, in Canada, Mexico or China. Those workers would be getting our jobs. We are the ones who need the jobs here, but these bills would be driving jobs offshore.

To conclude, I would like to just say that the survival rates for cancer in the United States are the highest in the world, higher

than Canada, higher than Europe, both of which have socialized, single-payer national health insurance systems.

We need to fix our health insurance system now. We need to make it more like auto, home and life insurance, where anyone can get it, where it is not tied to the employer, but we do not want to disadvantage American innovation. We do not want to disadvantage the job creation that we have had here in the United States that has made it possible for people to rise up from low incomes to high incomes. We do not want to force more Americans into bankruptcy through losses of their jobs.

With that, I will conclude. Thank you very much for giving me the opportunity to testify today.

[The prepared statement of Ms. Furchtgott-Roth appears as a submission for the record.]

Chairman WHITEHOUSE. Thank you very much. I cannot help but inquire. Did you actually read the bill that is the subject of today's hearing?

Ms. FURCHTGOTT-ROTH. I did, yes.

Chairman WHITEHOUSE. You did.

Ms. FURCHTGOTT-ROTH. Yes.

Chairman WHITEHOUSE. Because you never mentioned it once in your written testimony. You never mentioned it once in your testimony before the panel. So it is a little bit confusing to me that in a hearing on the Medical Bankruptcy Fairness Act, you seem to sort of veer across three lanes of traffic to attack health care reform proposals that are not the subject of this Committee's jurisdiction and have not a word to say about the bill itself, which you never mentioned.

Ms. FURCHTGOTT-ROTH. Well, I think that we have bankruptcy provisions right now in the United States that are doing a good job of dealing with the situation.

Chairman WHITEHOUSE. Did they do a good job for Ms. Burns?

Ms. FURCHTGOTT-ROTH. Well, Ms. Burns was in a very, very unfortunate situation, whereby both——

Chairman WHITEHOUSE. Bankruptcy tends to attract people with unfortunate situations, does it not? People with fortunate situations are very rarely in bankruptcy court, at least that is my understanding.

Ms. FURCHTGOTT-ROTH. It does. But what we need to do is also look at the unintended consequence of these different kinds of legislation and by making it much easier to forgive bankruptcy, what you are doing is encouraging more people to file for bankruptcy.

Chairman WHITEHOUSE. Well, I guess I will just leave it right there. I think I cannot make the—I cannot say anything better than that.

Ms. Mathur, I was interested, you indicated that you are completely sympathetic to the plight of families—I think that was the quote from your testimony—but when you discussed this issue in your written testimony, you talk about medical filers and your concern is that a medical filer, somebody like Ms. Burns, not that she has to sit down and go through credit counseling—I think you will agree with me that putting her through credit counseling is a complete waste of time and a totally unnecessary humiliation, correct?

Ms. MATHUR. Absolutely.

Chairman WHITEHOUSE. Absolutely.

Ms. MATHUR. And that is why I did not talk about it in my statement.

Chairman WHITEHOUSE. But your concern is that she would have an easier time walking away from their other dischargeable debts and that this would hit creditors particularly hard, a point you emphasized in your written testimony.

It is hard for me not to conclude from your testimony—you then go on to say that a medical debtor—the protections for the medical debtor would clearly lead to strategic behavior on the part of opportunistic debtors. Medically distressed debtors would get rid of their credit card debts.

It does not sound to me that your testimony is balanced between the interests of families like Ms. Burns' and those of the credit card industry. Wherever you have a chance to express actual sympathy in your testimony, the only place you express actual sympathy is to the credit card industry and to creditors, but in the context of creditors or people who have credit card debts of $42,000, which would, again, seem to be sympathy for the credit card industry rather than families.

And your closing remarks, suggesting that the most effective solution to Ms. Burns' problem is to create the right conditions for an economic recovery so that families can hold onto their jobs, retain their earning power, stay in their home and live within their means, seems to be almost nonsensically not correlated to the purpose of this hearing.

She and her husband had jobs. This occurred 4 years ago during a period of economic bubble, when the economy was going, frankly, as we found out later, unjustifiably strongly.

The reason they lost their earning power was not because of anything in the economy. It was because their son was diagnosed with cystic fibrosis. They cannot stay in their home because of that and they have done everything they can to live within their means.

So I really have some skepticism about whether your testimony actually reflects the sympathy that you claimed once you had heard her testimony. It seems to me it is highly one-sided.

Ms. MATHUR. I think the purpose of the testimony—and as I stated in my opening remarks—was that this particular act could be open to abuse and fraud. Whenever you introduce——

Chairman WHITEHOUSE. Let me ask you, at what point would you say that the tipping—let us say that there are, to use your number, let us say that 29 percent of bankruptcies are caused by medical bills. That is 30 percent of people in the bankruptcy court who were there not because they were improvident spenders, not because they had bad control over their family budgets, but because a family medical emergency hit them, something nobody can plan for.

So there you have got 30 percent of people in the bankruptcy court who are there for this reason, being subject to the means test, having what you agree is a preposterous credit counseling regime being imposed on them.

What if 5 percent of them took advantage of this to get rid of some additional credit card debt and the other 95 percent simply were relieved of that burden, at what point does the prospect of

fraud, in your view, tip in favor of leaving people like Ms. Burns having to go through credit counseling after she lost her son?

Ms. MATHUR. I would not recommend credit counseling for somebody like Ms. Burns. I completely agree with you. I never in my opening remarks made any comment about whether she should go through credit counseling because she had medical debts.

Chairman WHITEHOUSE. Well, you certainly did not say anything——

Ms. MATHUR. The whole point of my testimony is that the act that you are recommending, the act that you are proposing could be used in unintended ways and it is very important that we realize exactly what we are getting into when we sort of adopt it wholeheartedly.

It is not for people like Ms. Burns who are clearly there because of genuine medical problems.

Chairman WHITEHOUSE. Did you support the original act?

Ms. MATHUR. But there is a big literature out there which does talk about opportunistic debtors who can——

Chairman WHITEHOUSE. Did you support the original Bankruptcy Reform Act?

Ms. MATHUR. Yes. I think that there are good points to it and I think that——

Chairman WHITEHOUSE. Were you concerned then about unforseen consequences for people like Ms. Burns who have credit counseling?

Ms. MATHUR. I think there will always be people like Ms. Burns who are genuine and who will face, even under—I mean, you cannot get rid of the problem that people will face illnesses and injuries and they will go through problems and you need to have a system to address their needs.

The problem is that if you introduce an act, you need to understand what the consequences could be for people who may take advantage of these acts, as was clearly the case before the Bankruptcy Reform Act of 2005, and you had people, when——

Chairman WHITEHOUSE. I understand your point. My time is running out. So I am just going to conclude by saying it very much seems to me that the concern over unintended consequences that you appear to have is concern over consequences to credit card companies and not concern over unintended consequences to people and families like Ms. Burns'.

Ms. MATHUR. I think the consequences for the credit card system would have unintended consequences for debtors, which was also the tone that I took throughout my testimony.

If you affect the market for credit, it is not just going to affect the creditors. It is going to affect debtors in the sense of their ability to get loans and the ways in which they can get loans and you may make the system worse for them than you think you are making it right now.

Chairman WHITEHOUSE. My time has expired. The Ranking Member?

Senator SESSIONS. Well, Ms. Burns, under your circumstances, perhaps it was pretty clear, after you went online and did the computer system on credit counseling, that you qualified for bankruptcy and you would not have to—but the reason that was passed

is because a lot of people are on the margin between whether they should file bankruptcy or not.

Lawyers that they go to do not get their fee unless they file bankruptcy and many of them just are cold-blooded number-oriented lawyers and if it benefits them in the short term financially, they will recommend that that is what they do.

So it was an idea that we would provide an opportunity for a reasonable fee, and that can be waived, too, and many people do get that fee waived, to go through a system to get a little outside perspective on whether there is a possibility that the individual could work their way through their debts without going into bankruptcy, and that was the motivation for it, not to—and I hope that—I am sorry that you felt that it was demeaning to have to answer those questions, I really am, but I think it overall is a good thing.

I would like to repeat—an individual, let us say, did act irresponsibly and had no insurance, and you had insurance, and they had been going along fine until all of a sudden they had a serious injury or illness and had very large debts, let us say, several hundred thousands of dollars or may be more.

They are able, are they not, Professor Pottow, to file bankruptcy if their income is below the median income in America and wipe out all of those debts and not pay their doctors or their hospitals?

Mr. POTTOW. Oh, sure, they can file for Chapter 7 with eligibility if they are below the median income automatically.

Senator SESSIONS. And do you agree that about 80 percent of the people are median income or below that file bankruptcy?

Mr. POTTOW. Yes. The majority of people—I would say the large majority of people who currently file in the bankruptcy system are below the median income.

Senator SESSIONS. If you were pretty cold-blooded about it, you might say, "I do not think I will take out insurance. I believe I am pretty healthy and I might just beat this system," I hear Ms. Mathur and Ms. Furchtgott-Roth indicate, and, economically, they would say, "Well, if I do get in financial trouble for illnesses, I can always bankrupt against it."

I am not sure how many people think that way, but economic forces tend to have effects in the long run. So I just would say that what the current law is is that if you have any debts and they are above median income, that an individual can—and they make below median income, they can all be wiped out and they do not have to pay their hospital a dime.

If they make above median income, a judge decides how much they can pay and orders them, over a period of three to 5 years, to make some payments back toward those debts.

Do you think that is unjustifiably harsh?

Mr. POTTOW. Well, you raise the proposition of the economic effects of incentives and this is what—in terms of what Dr. Mathur was saying, she was speculating that there is a possiblity that there could be opportunistic behavior.

But with any rule, with any economic incentive crafted by anything, when there is an insurance or protective function, there always is a moral hazard concern.

If I have health insurance, there is the risk that I could say, "Hey, let's see if I can jump out the window and if I break my

arms, that is OK, someone else will pay for it." You have to then step back, once you have speculated on the economic possibilities, about whether that will actually affect people's everyday lives.

So the risks of someone like Ms. Burns then sort of thinking, "OK, now, maybe I can ring up some credit card bills," after they have gone through a traumatic medical loss like that, strikes me as, while I suppose economically conjectureable, empirically and pragmatically unlikely, not enough that it would generate great concern.

Senator SESSIONS. But it does sound to me that Ms. Burns meets the very reason we have bankruptcy procedures and I certainly do not denigrate the difficult situation she went through. But there are people who do take advantage of it, there is no doubt.

Professor David Dranove, who is a Walter McNerney distinguished professor of health industry management and director of the Center for Health Industry Market Economics at Northwestern University's Kellogg School of Management recently wrote the following about the Warren study on a blog post.

Quote, "I realize that the concept of medical bankruptcies is captivating and my research confirms that the uninsured case face severe financial hardship when illness strikes, but the Harvard studies are so poorly designed that it is impossible to tell from their work just how serious the problem is and the conclusion that private health insurance does not protect against bankruptcy appears to be totally misguided. Even worse, the Harvard studies are leading to bad policy." Other than outright fraud, I cannot think of a worse thing to say about academic research. As I've said before, it is vitally important that academics get the numbers right.

Now, he supports a national health care system. He is not opposing a national health care system. But, I guess, Ms. Mathur and Professor Pottow, would you all comment on that statement?

Ms. MATHUR. I think as an economist, I think I would agree that the design of the study is—it is very poorly done. The first issue with the study is what is called sample selection. So they only looked at people who had already filed for bankruptcy and that is the only truth and then you start asking people, "Well, did you have any medical reasons for filing for bankruptcy," and, obviously, you come up with a really high number.

But if you start—with most economic studies and most good published literature in economics, the way you start off with a sample is to look at a group of people with medical debts, without medical debts, people who have filed for bankruptcy, people who have not filed for bankruptcy, and look at the probabilty that the fact that you have medical debts will lead you—what is the likelihood that your medical debts are likely to lead you to a bankruptcy filing.

And there is nothing in the economics literature to suggest the huge effect that the Himmelstein paper finds. That is purely a sample—a problem with the way the sample is designed.

The second problem is, again, the methodology. The way you would do that kind of analysis is to also account for the 10 other things that could have led to the bankruptcy filing. Did the person lose his job? Is he going through a divorce proceeding? Are there other economic conditions in the state where he stays in, in the region that he lives in, that could have led to, say, the bankruptcy

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filing or that could have led to a pile-up of medical debts that could have caused the filing.

And there is nothing in the study that lets you—that controls for any of those other factors or that even tries to deal with the sample issue and that is the only reason. It is only survey data which is leading you to that high number.

And as several people have pointed out, other surveys find vastly different results and much lower numbers. So you could look at another random sample and say, well, how many people, for instance, in the PSID data, the panel study of income dynamics data, how many people in that data set said that they filed for bankruptcy due to medical reasons, that is only 16 percent.

Senator SESSIONS. We are running over and I appreciate that. Professor Pottow, would you like to respond?

Mr. POTTOW. Yes. Survey data is a perfectly legitimate academic way to collect information on the problem. We would have to throw out the whole field of sociology if we were to not use it anymore and that would be, I think, a loss to the academy.

The methodology is not suffering from a sample bias. If you want to ask people who are bankrupt why they went bankrupt, then it is not a sample selection bias to restrict that to people who are in bankruptcy. It is, in fact, the only appropriate audience to ask.

I do agree that from sort of a first position, academically perfect way to study something, if you could perfectly categorize debts, get the credit card debt that is really medical debt and get the collection debts and get the home equity lines that are really medical debts, if you could do a controlled thing by having people who have a lot of medical debts to see if there is a causal inference, then a regression might be helpful, but I do not think it undermines the validity of the data that when you collect survey evidence from people, you ask them to ascribe reasons for their bankruptcy—that is robust. The Consumer Bankruptcy Project, this data that we have, is the largest national sample that does this sort of survey data.

The only other survey data that is out there that even comes close to this is the PSID and even that has suffered from methodological infirmities that have been well documented, including the incorrect response rate for people predicting their bankruptcy incidence and that I think led them to not even use the bankruptcy questions anymore.

So regarding this reference to the large corpus of economic literature: there are a bunch of economic studies out there, but they do not have the level of detail and sophistication and nuance that this Harvard study has.

They do not aggregate. They cannot properly predict the medical debt incidence because they are using too crude of a metric and they say either you are a credit card debt or you are a medical debt and they miss the boat.

Chairman WHITEHOUSE. Well, I appreciate this, but I think it is time to get on to another questioner.

Senator SESSIONS. Mr. Chairman, I do not have any doubt that a number of people, a significant number file bankruptcy because they have medical debts. I am just reluctant to conclude the current system that allows median income and below to file Chapter 7, as they always have, is unfair and those above median income

would have to pay back some of their debts over a period of years, if they are able. I do not think that is unfair, basically.

Chairman WHITEHOUSE. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman, for calling this hearing on your bill and I want to thank the witnesses who spoke to it.

Professor Pottow, in your testimony before the House in July, you mentioned that the 2005 bankruptcy reform was particularly bad for people with medical debt. Tell me why you think people with medical debt deserve special protection under bankruptcy law.

Mr. POTTOW. Well, I think that there was—I do not want to speak for people who passed the legislation, but there was a suggestion that there was a rampant incidence of abusive and strategic behavior that required amendments to the bankruptcy code to make sure that people who could pay back their debts—and the way it was implemented was through an income measurement—should be forced to pay them back.

And so it was called the anti-abuse amendments, with the idea that you were going after abusive people, system gamers, deadbeats, and it seems to me that the antithesis of that is someone who has filed for a medical reason through no fault of their own, through no strategic conduct. They are, per se, not an abuser.

So that is why I said that there was, I believe, a different moral justification for treating them differently. But I am not an expert in morality. I am just a bankruptcy person.

Senator FRANKEN. Ms. Edwards, in your written testimony, you note that according to one survey, medical expenses helped cause 70 percent of home foreclosures, and I think a lot of people do not realize that.

Before the bubble burst, you could buy a house and if you got sick, you could sell your house. Now you cannot.

What significance do you think that has, people essentially being stuck in their homes, has on the situation that people who are ill find themselves who have a home?

Ms. EDWARDS. I will put my bankruptcy lawyer hat on for a second. If I had someone who came to me with these kinds of problems, that they had these high debts and they were not able to—high medical debts, they were not able to—did not have the fluidity in their economic situation to sell their house, their largest asset, they have already dipped into their savings or their retirement funds, as the Burns had done, but they were sort of locked into the situation because the value of their house had decreased perhaps below the mortgage level and so that asset on which they might have counted was no longer available.

So your advice as a lawyer would be that your bankruptcy was going to—you would actually be advising people more to go into bankruptcy because of the present economic situation.

I have to say something about the anti-abuse section and that is that in the 2005 bill earlier is that it was not considered or was rejected with some limitation on the homestead exemption. It is very frugal. In Alabama, it actually is malpractice practically not to advise someone to move to Texas or Florida with their incredibly generous homestead exemptions.

So if you wanted to stop abuse, this little narrow section that Dr. Mathur talks about is just not where you want to put your attention. You might want to put your attention on a much larger problem with a much larger asset than somebody, even if you are talking about $42,000 in credit card debt, which, most of the time, you are not talking about that.

The notion, I think, that we have people who are out there trying to defraud, we have people who are doing just what you were talking about, they are in this terrible situation, they are trying to figure out a way out. They do not have access to their home as an asset and they are not planning ahead.

As a matter of fact, most people are planning not to go into bankruptcy. They are finding ways not to go into bankruptcy instead of planning what they are going to do so that they can somehow game the system in bankruptcy.

People do not want to do it, because, in part, as Ms. Burns described it, it is an extremely humiliating, shameful condition. In The Two Income Trap, Professor Warren discussed the fact that 50 percent of American families teeter on this razor blade with the idea that they might have to file bankruptcy.

Well, if there is a divorce next door, you know if somebody moves out, there are suitcases on the lawn. If there is a bankruptcy next door, you do not know it. So this is something that is happening and lots of families who just simply do not know it.

If I could address one thing that Dr. Mathur said, and I apologize for taking your time to do this, she said that medical indebtedness has not increased over the past decade or so.

Without arguing with that position, which I think is arguable given what has happened to medical costs, it makes no sense for her to say then that we have to—that she knows bankruptcies are up, that creditors, in fact, are being put into a situation where they are only going to get pennies back on their dollar.

So we already have, without medical bankruptcies going up, we already have this upward pressure, supposedly, on interest rates and on restrictions of capital.

If we only were talking about 29 percent of people, which is the number, I think—is that the number that you are willing to accept? My recollection from the House testimony is your number was not significantly different from 29 percent.

If we are only talking about 29 percent of the people who have medical bankruptcies and that the system is unfair to them, why in the world would you not fix it?

Senator FRANKEN. I have to agree with that. Dr. Furchtgott-Roth, I think we disagree on whether health care reform, the health care reform that we are talking about now and Congress should pass, and you said that kind of the way we are going will increase bankruptcies.

I want to ask you how many bankruptcies because of medical crises were there last year in Switzerland?

Ms. FURCHTGOTT-ROTH. I do not have that number in front of me, but I could find out and get back to you.

Senator FRANKEN. I can tell you how many it was. It is zero. Do you know how many medical bankruptcies there were last year in France?

Ms. FURCHTGOTT-ROTH. I do not have that number, but I can get back to you, if you like.

Senator FRANKEN. The number is zero. Do you know how many were in Germany?

Ms. FURCHTGOTT-ROTH. From the trend of your questions, I am assuming the answer is zero, but I do not know the precise amount and I would have to get back to you.

Senator FRANKEN. You are very good and very fast. The point is that I think we need to go in that direction, not in the opposite direction. Thank you.

Ms. FURCHTGOTT-ROTH. Do you know the cancer survival rates in those countries?

Senator FRANKEN. You know, you have picked on one—and if you look at that study, did you know that we pick, easily, much more easily survivable cancer rates? So if you want to start getting into digging deep into studies, that study is not legitimate. I have heard that before.

That is because we find easily survivable cancers that count as ones that we survive. So you can cherry-pick stuff to find one little place where somebody says our system works better than the French or the Germans, but we are talking about bankruptcy here today.

The fact of the matter is you are saying that if we go more to a French system or a Swiss system, that we will have increased bankruptcies, but the fact is they do not have bankruptcies and we do for medical care.

Thank you.

Ms. FURCHTGOTT-ROTH. The fact is also that the Himmelstein study did not——

Chairman WHITEHOUSE. Senator Feingold.

Ms. FURCHTGOTT-ROTH.—prove that there is a problem.

Chairman WHITEHOUSE. Thank you very much.

Ms. FURCHTGOTT-ROTH. When Dr. Pottow was saying about how surveys are a very good way to——

Chairman WHITEHOUSE. Senator Feingold is recognized. We have time for each Senator to ask their questions and answers.

Senator FEINGOLD. Thank you, Mr. Chairman, for holding this hearing to call attention to this very important topic. I support your bill, S. 1624, and ask that you add me as a cosponsor, please.

I agree with you that the issue of medical bankruptcy should be part of the upcoming health care debate in the Senate. I opposed the bankruptcy reform bill that became law in 2005 for many reasons, but the overriding reason was that I believed it was a blunt instrument designed and pushed by powerful interests in the banking industry that would harm the most vulnerable Americans while achieving very little of the abuse prevention that was supposedly its purpose.

So the situation we now have with medical bankruptcies is a prime example of the shortcomings of the law. So I commend you for focusing the Senate's attention on this.

The rising cost of health care is, of course, well known to everyone here and everyone in the country, but the effect of those cost increases on bankruptcy filings is not as well known.

One recent study estimates that medical debt is responsible for over 60 percent of bankruptcy filings in this country. That is really an extraordinary number. While I recognize that there is some debate over that number, virtually everyone agrees that the number of bankruptcies attributable to medical problems is growing very rapidly.

Now, this problem is hitting the elderly especially hard and, remember, these are the people who almost always have insurance coverage because of Medicare. Yet, the percentage of bankruptcy filings by people over the age of 65 is over three times what it was in 1991 and medical debt is almost certainly a big part of the reason for that.

So we have an increasing number of Americans filing for bankruptcy because of medical debt, yet they face a bankruptcy system that was designed to put roadblocks in their way because Congress said it wanted to weed out deadbeats and spendthrifts.

It is a minor example, but let us take the requirement that has already been discussed of credit counseling. What exactly is a credit counselor going to tell a family that has lost everything as they struggled to pay the medical expenses for a fatally ill child, like one of our witnesses today, or faces huge medical bills and nearly complete loss of income because of the catastrophic illness of the primary breadwinner? What purpose is served by the burdensome paperwork requirements of the means test in cases like that?

It is time for Congress to recognize that the 2005 bankruptcy reform bill is causing unnecessary and unfair hardship to people who no one thinks are abusing the system.

Senator Whitehouse's bill contains some common sense and quite moderate measures to try to reduce the burden for people whose financial problems are caused by medical problems. It is an important piece of the very complicated and very important puzzle that the Senate is going to be addressing in the next few months.

I want to ask Professor Pottow to elaborate on his written testimony concerning the role that medical expenses are playing in the increasing number of bankruptcy filings by the elderly.

To me, this is a chilling statistic, because Medicare is supposed to alleviate the financial hardship of medical problems for the elderly. What is happening here?

I would also like to hear from my friend, Elizabeth Edwards, on this point, as well.

Mr. POTTOW. Thank you. Yes. This is a very disturbing trend and I am glad you are asking for the numbers and the data, because even these credit counseling requirements, they cost, on average, about 50 bucks. And going through twice, I am sure you, Ms. Burns, had to pay for them. So even if you pass the means test, you still have to pay for this.

In terms of the elderly, the data that I had is on the survey evidence specifically saying, "Why did you file for bankruptcy? Was it a medical reason, medical problem" 39.1 percent of the people who are 65 or older for the primary or secondary petitioner or 6.8 percent of another family member said yes. If you specifically said, "It was medical bills were the reason I filed," you can add another 32.5 percent.

Anyone answering either of those reasons was 49 percent. So half of the people are actually specifically saying on a questionnaire it was because of an illness or because of a medical bill and these are people over 65 who should be covered predominantly by the Medicare program.

So that is why I want to urge this Committee, let us not lose the forest for the trees. We can debate 60 percent, 40 percent. We are talking about big numbers and at a certain point, your job is to move things forward, I believe.

Four percent of them had to mortgage their home, of the over 65, to finance these medical bills; loss of 2 weeks of wages was 11 percent, that is less interesting because a lot of them are retired already of the over 65 group.

Then for a definition that sort of gets at what you guys are talking about with this bill here: incurred more than $5,000 or 10 percent of their annual income in out-of-pocket expenses was 30 percent of the over 65 group.

I will let Ms. Edwards talk now.

Ms. EDWARDS. The elderly, 50 percent or more of people who come into Medicare come in with two or more chronic conditions. So you are talking about a population that is generally sick and it is not just they are sick today, they did not jump out the window and break their arms.

They have chronic conditions that are going to continue to cost them money and it is one of the reasons why it is really important for them to have access, non-punitive access to bankruptcy.

I have to say this is also true in terms of chronic conditions. A large number of these people who are coming into bankruptcy court with these extraordinary medical expenses, the extraordinary medical expenses are unlikely to be from—or they are less likely to be from a single catastrophic incident, an accident or something, as they are from the kind of condition of cystic fibrosis or cancer that have long-term costs over time, which is why the means test turns out not to be particularly adequate, because what happens to these people is they get into the system, they have got a repayment schedule, the condition still exists.

The medical condition still exists. They are still going to—the day after they file bankruptcy, they are still going to have medical costs that they are incurring.

So if they could start with a cleaner slate, again, it would make an enormous difference in the lives of these people and the ability they have to pay attention to what it is they should be paying attention to—the health of their family or the health of themselves.

I wanted to, if you do not mind, answer a question. Cancer, in the test with respect to cancer, cancer is not identified adequately in our population, because it is not adequately identified in the uninsured population.

When you do not have an uninsured population, when you have universal care, more cancers are going to be identified and, therefore, the cancers in the least well population, the population with the poorest health, which are the people who are least likely to be insured, are going to be treated in other countries and not here.

Senator FEINGOLD. Thank you, Ms. Edwards.

Professor Pottow, can you just clarify another matter? People who make less than the median income are not subject to the means test, but they still have to comply with the test's burdensome paperwork requirements. Is that not one of the things that this bill would change?

Mr. POTTOW. Yes, indeed. And another consequence, too, is that everyone, after this bill in 2005, has to pay much more for the attorneys' fees. This paperwork has caused attorneys' fees to go up by about 50 percent, and that is not just my data. That is confirmed by the General Accounting Office.

So the big winners are the people who process the system in terms of the fees. It has made everything more expensive. Even, I must say, pursuant to Deficit Reduction Acts, the filing fees for bankruptcy have gone up, not only the attorneys' fees.

So every step of the way, it is cutting down these people with incremental costs, even if they ultimately end up succeeding and passing the means test, they still get dinged by these costs along the way.

Senator FEINGOLD. Thank you, Mr. Chairman.

Chairman WHITEHOUSE. Thank you very much. Courtesy among Senators is very important around here, and so I had to cut off Ms. Furchtgott-Roth because it had become Senator Feingold's time and she was still addressing Senator Franken.

But now that it is back to my time, I would like to invite her to finish whatever it was that she wanted to say, and then I will have a question for Ms. Burns.

Ms. FURCHTGOTT-ROTH. Thank you very much, Mr. Chairman. I just wanted to say that even though I agree with Mr. Pottow that survey data are a standard way of finding results and economics, this particular survey, in the Himmelstein, that he used is not standard. He had 5,251, a sample of that size, but then he whittled it down to 639. So there were all these observations he did not use and it was not necessarily random with that small amount.

Second, the reasons for medical bankruptcy were not distinguished. If you had $1,000 of uncovered medical spending in 2 years, you were counted as being medically bankrupt. That is $500 in 1 year. Many families have $500 with dental appointments, copayments, that kind of thing.

Also, he said that a loss of 2 weeks income from illness automatically put you into a medical bankruptcy category, even if you did not have medical expenses at all.

So say you were a salesman and you had 2 weeks off because of the flu. You were still counted as being medically bankrupt. That is not standard survey economics or sociology technique.

Thank you.

Chairman WHITEHOUSE. Thank you. Just one final question. Should Ms. Burns have had to undergo credit counseling in her circumstance?

Ms. FURCHTGOTT-ROTH. I think that all the decisions that Ms. Burns made were absolutely right in her circumstances.

Chairman WHITEHOUSE. And should she have had to undergo credit counseling in her circumstances?

Ms. FURCHTGOTT-ROTH. I do not know the answer to that question.

Chairman WHITEHOUSE. Under what circumstances could the answer possibly be yes?

Ms. FURCHTGOTT-ROTH. I think that making policy by anecdote of one person is not a good idea.

Chairman WHITEHOUSE. I did not ask you policy. I asked you should Ms. Burns have been subjected to credit counseling.

Ms. Furchtgott. And I said that whatever happened to Ms. Burns was absolutely correct and that I do not comment on what she should have done and what she should not have done. She had extremely unfortunate circumstances and I think that she and her husband have borne this in an extraordinary manner.

I myself would not have been able to get up and testify the way she has without managing to hold myself together the way she has, and I have great admiration for her and her husband and all the rest of her family, also.

Chairman WHITEHOUSE. Ms. Burns, could you tell us a little bit more about the actual process as it worked out for you and for Mr. Burns as you came to file?

You mentioned the credit counseling, you mentioned the document preparation. Could you flesh that out a little bit and tell us how long it took, what it was like?

Ms. BURNS. We are still actually in the process. We first met with lawyers in April, about a month after our son passed away, which was incredibly difficult. We did not have all of our paperwork. We were sort of between homes. We were living in D.C., then living with friends. So it took some time for us to gather all that paperwork, because it is quite extensive. Lots of documentation is needed.

So as that process went on, we learned that it would cost $1,300 in a filing fee. We had already paid $250 as a retainer, which helped stop the calls that we were getting from our creditors for a short time. They are starting again.

In terms of once we found out that it was going to cost $1,300, we did not have that money. We came back with literally nothing. We lost our son and we literally had no assets.

So it took some time for us to find a way to get some money to pay the actual filing fee. So that happened in August. Again, we needed to clarify some of the documentation, some of that sort of thing.

In September, we sat down to take the credit counseling course and it was sort of a slap in the face, honestly, and we have not yet finished that course. We logged off and needed to walk away from it for a little while.

So our plan is to do that. We have not done it yet, though, because it is really incredibly painful to go back in and we had to reascertain all of the numbers that we had given to our lawyers and sort of re-dredge up all of that information in order to—it was not just the questions about how could we have not gone bankrupt. It was, again, having to give every single bit of information about income, debt, where our debt is coming from, what the amounts are, and having to go step-by-step through that process again.

Chairman WHITEHOUSE. Even though you had already done it with your lawyer, you had to do it again for this program.

Ms. BURNS. We had to do it again for the program and there is no doubt, in our minds, that we are filing bankruptcy. There is no doubt, there is no question, in our lawyer's mind, that we need to file bankruptcy.

It is simply you need to do this, because, well, that is the rule and you need to do it.

Chairman WHITEHOUSE. But you have no choice. You still have to——

Ms. BURNS. WE DO NOT HAVE A CHOICE.

Chairman WHITEHOUSE. Is there a person that you are talking to or is it just a computer program?

Ms. BURNS. It is a computer program and they actually called—they did call us, because we logged in, started the process, and we stopped.

So a few weeks after that, we did get a call saying, "Hey, were you having a problem with the system," with the computer part of it, which was not the problem. And we also, after we file, need to take anther course.

Chairman WHITEHOUSE. There is nobody you could go to and say, "Listen, you do not understand."

Ms. BURNS. No.

Chairman WHITEHOUSE. "My son died and here are the circumstances that we are in."

Ms. BURNS. No.

Chairman WHITEHOUSE. "Putting me through this is preposterous. Would you please stop it?" You just have to go and keep going to that computer program. And it is just a computer program. It is you versus the computer. There is not even a person on the other side.

Ms. BURNS. Right. And we will need to do it again after we actually go through the filing process and meet with the judge. It is a requirement after you file, as well, so that you can, I guess, get an idea of how to not do the same thing again in the future, which is an incredibly hurtful idea that I am not looking forward to.

Chairman WHITEHOUSE. Well, I can appreciate that. And on top of being subjected to, did you say, 20 or 30 collections calls a day, including right into the hospital where you were tending your son——

Ms. BURNS. Yes. It was 30 calls a day to each of our cell phones. We each had a cell phone and that was our lifeline to our family back home, particularly when we were in D.C. And we had to shut our phones off. I mean, it was 60 calls a day.

Chairman WHITEHOUSE. I could see that, as difficult as it would be, the first four or five or even 10 times having to explain what your circumstance is and what your family circumstance is and where you are and your son are right there and he is in an intensive care unit.

But 20 or 30 times, it must just get to be extraordinarily burdensome to have to have that conversation over and over and over and over and over and over again.

Ms. BURNS. Absolutely. And we did make a good faith effort, when we knew that our money was running out, to contact all of our creditors and we really did not get anywhere with them and then the calls started and did not stop and still continue.

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Chairman WHITEHOUSE. And because of the delay in getting through the bankruptcy process, which is caused by the delay in having to go through this completely nonsensical credit counseling, you also continue to have to answer those questions about your debt situation and deal with collection calls.

Ms. BURNS. Yes. Yes, we do.

Chairman WHITEHOUSE. I am sorry.

Ms. BURNS. Thank you.

Chairman WHITEHOUSE. The Ranking Member?

Senator SESSIONS. Well, sometimes—let me just say this about credit counseling. You can go to a local credit counselor and you can also get approved to not have to pay that and we do know that quite a number of people who are in bankruptcy have difficulties managing their money and they did not know some things that got them into trouble.

Had they been able to learn more about how to manage money, they could avoid that in the future, and that is why, when the government starts to regulate anything, take over health care, you have rules and that was one of the rules we agreed to on the bill, that a person would inquire before they file, because they can find that they are able to work out a bankruptcy and there are other ways to avoid it, and, hopefully, you can——

Chairman WHITEHOUSE. Can I interrupt you for a question?

Senator SESSIONS. Yes, you can.

Chairman WHITEHOUSE. In what way could there possibly be more intrusive government regulation than to have the government require that Ms. Burns, who has just lost her son, has to deal with a computer for weeks at a time and do all this stuff, with absolutely nobody to talk to and let her out of the situation?

Senator SESSIONS. It is not weeks at a time. It is you file the matter and if you have got the information, you provide it to your lawyer. I am under the impression it can be done within an hour.

Chairman WHITEHOUSE. Did it take you an hour?

Ms. BURNS. No, it did not and, unfortunately, we have been between three houses, three different living arrangements since we returned from Washington when we lost our son, which included having to clean out our house, having to put our things in storage because our house was going to be foreclosed on, and it was foreclosed on in August, we lost it, and trying to obtain other housing.

There were other things that were a little bit more relevant to our daily living, which included finding somewhere to live, having enough money to buy food and gas, trying to find employment, and, unfortunately, this particular thing just added an undue burden. And when I cannot avoid having to find money for good and gas, this other thing, I need to put that aside.

Senator SESSIONS. Well, there would be a potential option for you to seek to be able to go through that without a pay fee.

What about the $250? That is the initial retainer you paid the attorney. What do you expect the attorney's fees to be when the process is complete?

Ms. BURNS. I had no idea what the attorney's fees would be, I truly did not.

Senator SESSIONS. What did they tell you in addition to the $250?

Ms. BURNS. $1,300.

Senator SESSIONS. What about the attorney's fee?

Ms. BURNS. I know the filing fee is $1,300. I am sure that there are other expenses that are going to be included.

Senator SESSIONS. They did not tell you how much an hour they charge for that.

Ms. BURNS. We just got a set rate.

Senator SESSIONS. Or whether they would charge a flat fee.

Ms. BURNS. They told us $1,300. I honestly——

Senator SESSIONS. Well, it is going to be more than $250, I think.

Ms. EDWARDS. I would take that as a question to me, although you are just sort of nodding to me. I think that there are some sort of straight bankruptcies that are actually available at fairly limited cost. That is not the kind of work I did, so I cannot really speak to that.

But I think that there are some—I do not know what fees she is going to face, but I know that in my home district, the eastern district of North Carolina, that there are lawyers who do bankruptcies that sound similar to the one that the Burns are having to file that could be easily in that range.

Senator SESSIONS. You mentioned the homestead exemption. I have always thought that this was bizarre, that a person would be able to keep a multimillion dollar home and not pay their doctor or anybody else that they owed money to.

Do you have any feelings about that? That was a matter that we discussed and debated in the Senate when the bill came up and I supported—was it Senator Kennedy and I were in agreement on that issue. It came out $1 million, were you able to cap that at $1 million or is it unlimited now?

Ms. EDWARDS. I believe it is unlimited still. I think it came out of the Senate bill, but it did not survive in conference.

Senator SESSIONS. We passed it in the Senate and it did not survive conference, which is breathtaking to me that an individual can move to Florida or Texas or maybe Kansas and buy—they know they are going into financial difficulty. They buy a multimillion dollar home, pay cash for it, it is all equity in the home and then pay nobody that they legitimately owe debts to.

Ms. EDWARDS. When you are talking about the abuse, and I think that there is a narrow sliver of abuse, but my personal experience was you really do not see that much of it in actual practice, except perhaps for the advice to people that they should move to one of these states with such generous exemptions.

But your general concern about there being abuse, I think that these bankruptcy judges, for whom I have enormous respect, sit up there every day and hear one sad story after another sad story and they are very good at telling the difference between somebody who has got a legitimate case where they have ended up in bankruptcy court, sometimes because they have acted irresponsibly, sometimes because they have circumstances.

But those conditions of fraud, the bankruptcy judge has an opportunity to dismiss those cases. They can dismiss those cases. So when those situations exist that Dr. Mathur is concerned about, that you are concerned about, somebody is jumping out of the win-

dow, economically, at the chance of breaking their arms, I think that you can count on judges being able to identify this.

They are in the very best position, honestly. They are sitting with the debtor in front of them, with the creditors, who are going to give information, if they know it, right there in front of them.

The least likely people to make that determination are the people, frankly, including myself, sitting in this room so far away from these individual situations.

Senator SESSIONS. There is no doubt that overwhelmingly, the people that file for bankruptcy are entitled to it legally and probably benefit from it. I think a lot of people, if they knew the options and can negotiate some of the debts that they may have, might be able to work their way out of—avoid bankruptcy and would feel better about themselves and their credit rating if they are able to do so.

But when you have huge debts from medical care or other reasons or maybe just improvident living, that they just are not able to pay them, I think one of the great things about America is you can wipe out those debts and start over and it is something that I appreciate.

Mr. Chairman, this is a good discussion. I am sure we will continue it. We have a number of articles and studies that I would like to introduce as part of the record. We may ask these witnesses additional questions.

I would just say that right now, in America, a person who is hit with a huge medical bill, if their income is below median income, the average—well, not average—median income in America, they can wipe out all those debts.

If their income is above that, they can attempt to wipe them all out and the judge would decide whether or not they are able to pay some of them back, set up a repayment schedule under the Chapter 13 procedure and they would pay some of those debts back.

I think that is a legitimate process. I believe that is a moral approach that is consistent with our heritage and will eliminate—has eliminated some abuses.

So thank you.

Chairman WHITEHOUSE. I thank the Ranking Member very much for his courtesy and his participation in this hearing. I think we come at this from slightly different angles. I look at the credit card industry as having been behind the bankruptcy reform and that its primary purpose was to keep people harassed longer before they could get into bankruptcy, because at that point, they would be at 30 percent and they could keep getting billed.

So we have different views about the motivations and what was behind it, but I hope that this hearing creates the seeds for an agreement that people who are in Ms. Burns' position, having to go through the means testing, having to go through credit counseling and things like that simply does not make any sense.

It is a terrific and unjustified government intrusion, I believe, at the behest of the credit card industry, but that is neither here nor there, into their lives in a way that if you could, frankly, sit down with anybody, I think if even Ms. Mathur and Ms. Furchtgott-Roth were on the other side of the phone conversation with Ms. Burns,

they would say, "You are right, you do not have to go through this, this is a ridiculous situation that you are in."

So I think that there is at least the seeds for some potential further discussion and agreement on this issue and I appreciate very much your participation.

Senator SESSIONS. Well, I think there is a possibility of further discussions and maybe we can reach some agreement.

But I would just tell you that I do not agree with the idea that the bankruptcy legislation that got 83, I believe, votes in the Senate, people like Senator Hillary Clinton, who originally opposed it, studied it and voted for it, because they concluded it was a fair piece of legislation.

And it is a concern that people run up any kind of debts, credit card or otherwise, and just not pay them and they have advertisements on television. They can tell people that they can file bankruptcy and stay in their home 2 years and we fought over that and were able to improve some of that.

There are abuses in the system and these economists over here would tell you that if people are abusing the system, it is not just the credit card companies or the banks that lose, but everybody has to pay a higher rate of interest, in other words, to carry those losses.

So I just am a little—my back gets up a little bit when it is suggested that the bankruptcy legislation was a piece of legislation designed for special interests and did not have a good public policy behind it.

I stated in the core of the bankruptcy legislation that if you make below median income, you can wipe out all your debts. If you make above median income, unless the court finds that you can pay some back, you do not have to pay any back, and if the court finds you can pay some back, Mr. Chairman, should they not pay some back? Should they not pay the debt they obligated?

Chairman WHITEHOUSE. I think that there is a distinction that can be reasonably drawn between people who have deliberately run up debts and should pay it back and those who——

Senator SESSIONS. So you are saying if they have a medical bill, they have no obligation to pay their hospital, because that came out of the blue and they did not plan for it.

I would say you have an obligation if you can. If you cannot, you should not have to pay it and that is what the law says. If you can pay some of it, you can and should. If you cannot, you do not have to.

Chairman WHITEHOUSE. And I think what we are seeing over and over again—and, again, it relates back to the nature of the American health care system—is that because we leave families with this responsibility and do not have the kind of health care system that some other governments and countries do and because the health insurance industry sells products to people that lead them to believe that they have coverage, that it is complete and that they are protected, but ultimately somebody does something, through no fault of their own, in particular, a grievous illness in the family.

It strikes me that at that point, we are asking enough of that family if we are sending them into bankruptcy because of an

unforseen health care emergency and the question of whether or not they should pay a little or a lot is really secondary to the question of why it is necessary for American families to go into bankruptcy because of health care emergencies in the first place.

But as long as they do, I think they are entitled to be treated fairly and I think this legislation is at least designed, we can disagree over the elements of it and we can talk further, but it is at least designed so that for Ms. Burns and people like her, the bankruptcy experience is not so prolonged, expensive, humiliating and unnecessary.

The record of the hearing will remain open for an additional week for anything that the Ranking Member wishes to add or that anybody else wishes to add.

I once again appreciate the participation of all the witnesses, appreciate very much the participation of the Ranking Member. I think this has been an interesting and a lively hearing and I am grateful for it.

Thank you.

[Whereupon, at 11:41 a.m., the hearing was adjourned.]

[Questions and answers and submissions for the record follow.]

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QUESTIONS AND ANSWERS

Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?

1. In your oral and written testimony before the committee, you focused primarily on national healthcare proposals, explaining why you believe they are fundamentally flawed and will harm, rather than aid, the people at risk for bankruptcy. This focus led some to question your knowledge of S.1624, the Medical Bankruptcy Fairness Act. In fact, you had previously written an article entitled "The Healthcare Bankruptcy Myth," disputing the flawed statistics in a medical bankruptcy study conducted by Professors Himmelstein, Warren, and others. It was clear from your written and oral testimony that you believe the current healthcare proposals are both unwarranted and counterproductive; would you please elaborate your concerns about S.1624 specifically.

I have serious concerns about S.1624, the Medical Bankruptcy Fairness Act of 2009.

"Medically distressed debtors" are defined broadly in the legislation, leading to potential abuses.[1] The bill is not limited to patients, but also includes caregivers. It includes those who "experienced a downgrade in employment status that correlates to a reduction in wages or work hours,"[2] so someone who switches to part-time work or an easier job to care for an ill, injured, or disabled dependent would qualify to walk away from debts.

Further, in S. 1624, to identify as a medically distressed debtor, an individual could incur medical debts of less than $10,000 or 10 percent of his income within a twelve month period.[3] According to the U.S. Census Bureau, the 2008 real median household income in the United States was $50,303.[4] This then, could allow debtors to qualify for the medical bankruptcy provisions if their medical debt was above $5,000. The Nielson Report shows that the average outstanding credit card debt for households that had a credit card in 2008 was $10,679.[5] Consequently, households could file for medical bankruptcy even though high credit card debt might actually have been the real reason for filing and not medical debt. This could increase abuse of the bankruptcy system.

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[1] U.S. Senate "Medical Bankruptcy Fairness Act of 2009". 111th Congress, 1st session. S. 1624. Washighton: GPO, August 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1624is.txt.pdf

[2] Ibid

[3] Ibid

[4] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Available at: http://www.census.gov/prod/2009pubs/p60-236.pdf

[5] Ben Woolsey and Matt Schulz. 2009."Credit Card Statistics, Industry Facts, and Debt Statistics, " Available at: http://www.creditcards.com/credit-card-news/credit-card-industry-facts-personal-debt-statistics-1276.php#debt

In addition, S.1624 would eliminate the means testing. Under the provisions of Chapter 7 bankruptcy, medical debtors, who might be able to afford to pay off a portion of what they owe, would not only be able to eliminate all medical debts, but all credit card debts as well, causing further abuses of the bankruptcy system.

2. In your testimony, you quoted from an article by Ezekiel J. Emanuel and Victor R. Fuchs, entitled "Who Really Pays Health Care Costs? The Myth of "Shared Responsibility," published on March 5, 2008 in the *Journal of the American Medical Association*. That article discusses how insurance premium costs are passed along to workers through lower wages, higher taxes, and decreased availability of other government services. In your testimony, you argued that the current healthcare reform proposals would increase bankruptcies by increasing health care costs, increasing health insurance premiums, and decreasing the quality of care many people receive.

a. Would S.1624, which makes it easier for patients to avoid paying the providers of their healthcare for uninsured portions of those services, increase health care costs for paying patients?

S.1624 would increase health care costs for paying patients as well as for insurance companies. A study of more than a million Chapter 7 cases closed between 1994 and 2002 by the Department of Justice's United States Trustee Program (USTP) shows that in 96% of the cases, no funds were collected and distributed to the creditors.[6] The debts that are not paid affect the prices paid by all consumers of goods or services provided by the firm. Everyone pays more when individuals default on debt.

b. If it becomes easier for patients to avoid paying amounts owed as co-pays or deductibles under their current insurance plans, how is that likely to affect the costs of health insurance?

Health care providers are likely to increase their prices to make up for these lost copayments. The increasing burden of unpaid debts would ultimately fall on other patients, because medical professionals would increase prices or cut back on the quality of care in order to swallow the high costs associated with medical bankruptcies.

c. If your answer to part "2b" indicated that costs would go up, what effect would that likely have on the unemployment rate in America?

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[6] Flynn, Ed, Gordon Bermant, Suzanne Hazard. "Bankruptcy by the Numbers." United States Trustee Program (USTP), Department of Justice. Available at: http://www.justice.gov/ust/eo/public_affairs/articles/docs/abi122002.htm

Increases in the cost of health care will act like a tax. Higher taxes leave Americans less to spend on other goods and services and decreases demand, leading to more unemployment. Increased insurance premiums are likely to decrease demand for goods and services, deepening the recession and leading to higher unemployment. With the unemployment rate now at 10.2% for October, announced on November 6, this is a serious concern for many Americans. The fragility of the economy is such that anything that would discourage hiring should be avoided.

3. In her paper entitled "Bankruptcy and Consumer Behavior: Theory and Evidence from the U.S.," Economics Professor Michelle J. White of the University of California, San Diego reached the following conclusion:

> **On the credit market side, generous bankruptcy exemptions increase consumers' demand for credit by providing partial consumption insurance, but cause lenders to reduce the supply of credit by increasing the probability of default. In states with higher bankruptcy exemptions, consumers are turned down for credit more often and pay higher interest rates. If they have high assets, they hold more credit in high-exemption states; while if they have low assets, they hold less credit in high-exemption states.**

As you know, a bankruptcy exemption is, in the words of Justice Antonin Scalia of the United States Supreme Court, defined as "an interest withdrawn from the [bankruptcy] estate (and, hence, from the creditors) for the benefit of the debtor." *Owen* v. *Owen*, 500 U.S. 305, 308 (1991). S.1624 would allow people who meet the definition of a "medically distressed debtor" an exemption of $250,000 for their homes, which is greater than the amount provided by the laws of most states. Based on this fact and your expertise in economics, do you think S.1624 is likely to have the effect described by Professor White above?

S.1624 does permit higher bankruptcy exemptions than current law and thus would increase consumers' demand for credit by providing partial consumption insurance. This would then cause lenders to reduce the supply of credit and increase interest rates. Consequently, I do agree with the effects described by Professor White.

4. At the hearing, Senator Franken asked you several questions about the number of medical bankruptcies in Switzerland, France, and Germany; he then asserted that there were no medical bankruptcies in those countries. It is true that all of those countries have some form of socialized healthcare system, resulting in very few individuals having any medical debts; however, the bankruptcy laws of those countries also offer only very limited opportunities for debtors to obtain a discharge from their debts, whereas the bankruptcy laws of the United States provide broad avenues for discharge of debts in bankruptcy. In short, that means that a European

debtor in bankruptcy will still be required to pay some, if not all, of their debts, whereas a debtor under Chapter 7 of the American bankruptcy code can walk away from all of his debts and only lose whatever nonexempt assets he had at the time of filing.

a. Given the above-stated facts about European bankruptcy laws, do you think people in those countries would have much incentive to enter bankruptcy as a result of medical bills, even if those countries did not have a socialized healthcare system?

The personal bankruptcy law in the United States allows individuals who file for Chapter 7 bankruptcy to clear/wipe all of their debts, without losing all of their assets. Depending on the level of exemptions allowed in state filings, individuals can keep some or even all of their assets. Filing for personal bankruptcy can, therefore, give financially distressed individuals a "fresh start". This is reflected in the number of bankruptcy filings seen in the United States.

In contrast, individuals filing for bankruptcy in European countries are required to pay most of their debts over a sustained period, and in many cases have to give up their homes. In circumstances where there are no opportunities to walk away from their debt, there are very few incentives to file for bankruptcy, medical or otherwise. A 2006 paper by Michelle J. White, "Personal Bankruptcy Law: Abuse Prevention versus Debtor Protection" shows that while there were 6.8 non-business bankruptcies filing per 1,000 population in the United States, there were only 3.0 filings in France and 1.2 filings in Germany per 1,000 populations.[7] The bankruptcy laws result in fewer numbers of medical bankruptcies in those countries, regardless of the type of healthcare system.

b. Given the ready availability of discharge of indebtedness under American bankruptcy laws and the fact that the United States does not a have a socialized healthcare system, is it not true that S.1624, which would make it easier for individuals with medical debts to obtain a discharge of *all* of their debts (not just their medical bills), would create greater incentives to abuse the bankruptcy system by accumulating medical debts?

Chapter 7 bankruptcy law allows debts incurred as a result of medical expenses (as well as credit card debts and personal loans) to be discharged completely. (For instance, individuals with medical debts on their credit card can get rid of all the debts.) Under the Medical Bankruptcy Fairness Act, any individual who has a minimum debt of either $10,000 or 10 percent of their income within twelve months at any time in the three years before the filing is defined as "medically distressed debtor" and could file for Chapter 7 bankruptcy. Hence, patients or their caregivers with as little as $5,000 (10

[7] White, Michelle J. 2006. Personal Bankruptcy Law: Abuse Prevention versus Debtor Protection. Available at: http://econ.ucsd.edu/~miwhite/white-bapcpa.pdf

percent of the U.S. median household income of $50,303) or less in medical debt could take advantage of the high exemption allowed and get rid of their credit card debt as well. Due to the ready availability of discharge of indebtedness under the bankruptcy law, individuals might even be tempted to accumulate some medical debts, so that they can wipe out all of their other debts when they file for bankruptcy as a medically distressed debtor.

c. After the 2005 bankruptcy amendments, the United States' personal bankruptcy laws are very similar to those of Canada; however, Canada has a government-controlled, single-payer health insurance system. A recent article by Brett J. Skinner entitled "The Medical Bankruptcy Myth" points out that Canada's personal bankruptcy rate was 0.30 percent of the population in 2007. In that same year, the bankruptcy rate in the United States was 0.27 percent. Thus, the Canadian personal bankruptcy rate was similar to, but slightly higher than, that of the United States. Furthermore, Skinner asserts that, if we use the definition of a "medical bankruptcy" formulated in the Warren study, it is clear that so-called medical bankruptcies occur in Canada as well. In fact, among Canadians over 55 years old, approximately 15 percent cited medical reasons as the primary cause of bankruptcy. Is it not true that these numbers contradict claims that government-controlled health insurance will prevent the bankruptcies of a large number of Americans?

Analysis of Canadian and United States Government data have shown that, in 2007, the personal bankruptcy rates of Canada and the United States were .30 percent and .27 percent, respectively.[8] Thus, research shows that, even with a government-controlled, single-payer health insurance system, the personal bankruptcy rate in Canada in 2007 was similar to that of the United States. It is clear, then, that there is no evidence to support that the proposition that a government-run health care system would reduce medical bankruptcy in the United States.

5. I understand that economists sometimes use the term "negative externality" to describe situations where one person takes a course of action that benefits that person, but imposes most of the costs for that course of action on the rest of society. I also understand that these situations are particularly attractive courses of action, because the benefit to the person taking the action will necessarily be greater than its costs to him.

a. S.1624 would make it easier for people to obtain discharge of all of their debts, both medical and non-medical, by allowing them to file under Chapter 7 of the

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[8] Brett Skinner & Mark Rovere, Fraser Alert: Health Insurance and Bankruptcy Rates in Canada and the United States, July 2009, http://www.fraseramerica.org/Commerce.Web/product_files/HealthInsuranceandBankruptcyRates_US.pdf

bankruptcy code. Chapter 7 involves complete discharge of all a person's past financial obligations. Is it not possible that S.1624 allows one individual to impose costs on everyone else who uses credit in America?

As mentioned above, S. 1624 would lead lenders to increase interest rates on borrowing, thus imposing costs on everyone who uses credit. The bill would make it easier for individuals to file for bankruptcy under Chapter 7 and thereby discharge all of their debts, both medical and non-medical. Although this might be advantageous for the debtors, the burden would fall on the creditors and medical service providers. A study of more than a million Chapter 7 cases closed between 1994 and 2002 by the Department of Justice's United States Trustee Program (USTP) shows that in 96% of the cases no funds were collected and distributed to the creditors.[9] As I discussed in my answer to question 2 above, the losses to creditors in those cases are likely to be passed on to the rest of the credit market's participants because the creditors must raise prices to compensate for the harm these losses do to profitability. Therefore, there is a substantial potential for S.1624 to create negative externalities in the healthcare market.

b. If you answered question "5a" in the affirmative, is it not likely that S.1624 will increase the number of people filing bankruptcy, thereby increasing the costs imposed on everyone else?

As a result of the ease with which all debts can be discharged under S. 1624, more people would be tempted to file for bankruptcy. The increase in the number of bankruptcy filings would raise the cost of borrowing on everyone else.

The easy discharge of debts is likely to lead to increased filings because debtors file for bankruptcy when the marginal benefit of filing exceeds the marginal costs of doing so. For example, in their bankruptcy study report entitled "the Household Bankruptcy Decision," Scott Fay, Erik Hurst, and Michelle White concluded that: an increase of $1000 in households' financial benefit from bankruptcy would result in a 7-percent increase in the number of bankruptcy filings."[10]

c. If you answered question "5b" in the affirmative, is it not true that that S.1624 would likely lead to less available healthcare service for most people in America?

Under S. 1624, individuals who file for medical bankruptcy would avoid paying fees for medical services. Thus, the increase in bankruptcy filings, along with the rise in the cost of bad debts, would encourage medical service providers to raise their costs to all

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[9] Flynn, Ed, Gordon Bermant, Suzanne Hazard. "Bankruptcy by the Numbers." United States Trustee Program (USTP), Department of Justice.
http://www.justice.gov/ust/eo/public_affairs/articles/docs/abi122002.htm

[10] Scott Fay, Erik Hurst, and Michelle J. White, *The Household Bankruptcy Decision*, American Economic Review, Volume, 92, 706 (2002).

Americans, making everyone pay more for health care. Furthermore, the increased prices of healthcare services would likely lead to higher insurance premiums, causing some employers to cease providing their employees with health insurance.

6. As mentioned above, a great deal of your testimony before the committee was devoted to healthcare reform proposals currently under consideration by the 111th Congress. In doing so, you illustrated how those bills would lead to higher insurance premiums, lower wages, higher unemployment, and fewer jobs for Americans. You indicated that these effects will likely lead to more bankruptcies. If the current healthcare proposals become law, are those changes to the healthcare system likely to increase the negative economic effects of S.1624, which will make it much easier for individuals to avoid paying legitimately-owed fees for medical services?

If the current healthcare proposal becomes law, the U.S. economy would further deteriorate due to planned income tax increases in H.R. 3962 and proposed insurance excise tax increases in S.1679. These tax increases would cause businesses to create fewer jobs and unemployment to rise. This would increase the number of bankruptcy filings. The combination of the current healthcare legislation and S. 1624 would increase the probability that people could legitimately walk away from all personal debt. As I explained above, that would cause the price of health care services and health insurance premiums to go up, which would themselves cause the unemployment rate to rise. Therefore, all told, I believe that the health care proposals under consideration in Congress would lead to more bankruptcies, and a worse economy overall.

Aparna Mathur: Response to Questions Submitted by The Senate Committee on The Judiciary based on the hearing titled "Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?" on October 20, 2009

Response to Questions 1a and 1b.

The study cited in by Mrs. Edwards clearly suffers from several biases, the least of which is the small sample size of 128 people that is somehow supposed to be representative of a population of more than 300 million. Here are some problems with the study:

1) The sample for the study is too small and non-random to justify any belief in the estimate of medical foreclosures. For any survey to yield meaningful results, the sample size has to be appropriately representative of the large population and also to the extent possible, nationally representative through the use of appropriate weighting techniques. The survey conducted by the authors clearly does not meet these criteria. Moreover, it is not a random sample of homeowners, but specifically restricts the sample to those homeowners who have filed for foreclosure. By limiting the sample to those who have already filed for foreclosure, the study overstates the incidence of medical debt in foreclosures. The chosen sample is obviously one that has high levels of debt relative to income, so that any type of debt could cause a significant increase in the probability of filing for foreclosure. Therefore, it is not surprising that the respondents state medical debts as a significant factor in their foreclosures. Other significant factors, not specifically mentioned in the study, would include any other type of debt such as credit card debts. This is not an indicator of medical debts causing the foreclosure. The cause could have been job loss or divorce, but since the respondent was unable to pay bills as a result of that, what we are observing is the co-existence of high bills and low income, rather than a causation. To account for causation, the study sample should have, at the very least, included a "control" group of medical debtors who did not file for foreclosure. In other words, if the authors were trying to establish whether medical debts *cause* foreclosures, the appropriate sample should have included households with and without medical debt, and households who filed or did not file for bankruptcy. In short, what the authors have established is some correlation, but not causation.
2) The study also should have allowed for the possibility that other household characteristics, such as the filer's work status, marital status, income, and other kinds of debts could have influenced the foreclosure. As is now standard in any economic analysis, this could be done through the use of appropriate regression techniques applied on a suitably large, random sample of filers and non-filers. The study does claim to have done multivariate analysis, but the sample problems persist in that analysis as well.
3) The study uses an overly broad definition of "medical debtors," which includes people with gambling problems, drug abuse or alcohol problems and people experiencing births or deaths in the family. Further, it includes people who experienced any lost weeks of work due to illness, whether or not they actually lost their job because of it. The survey results shown in Table 3 of the study clearly state that only *23* percent of the respondents believed that their foreclosure was actually *caused* by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than $1000 in medical bills, and the percent of people

reporting any medical problems. This is clearly an overstatement of the problem. Since the respondents themselves do not believe that these other factors caused the foreclosures, it is wrong to ascribe the foreclosures to their medical costs. A related point is that the survey fails to provide information on other causes of foreclosures or how the respondents would rank different factors. Therefore, it is unclear whether medical bills were the most important cause or just another cause.

Based on my reading of the study, I do not believe that the results are representative of the entire United States or even of the four states that were surveyed, and the effect of medical bills on foreclosures is open to question.

Response to Questions 2a and 2b.

The definition of a medically distressed debtor is open to abuse and fraud. By definition, a medically distressed debtor is anyone who incurred debts of the lesser of $10,000 or 10 percent of income at any time within a twelve month period in the three years prior to the filing. To see what this implies for the actual level of medical debts, it is helpful to look at a typical distribution of bankruptcy filers by income level. A study of the distribution of bankruptcy filers by income in 2000-2002 showed that more than 85 percent of filers had annual incomes less than or equal to $48,000, with almost 60 percent earning between $24,000-$36,000.[1] This means that if the average filer spent about $2400-$4000 on medicines or medical care in any year, then they would qualify for a medical bankruptcy. This seems like a relatively low level of debt considering that the same study shows that credit card debts average approximately $20,000 for this group of low-income borrowers. In the worst case scenario, this could create perverse incentives for households since by accumulating a relatively lower level of medical debt, they could take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of their high credit card debts. In fact, it might even tempt households to accumulate other types of debt prior to the filing, since they are eligible for debt discharge under Chapter 7. Therefore, by allowing debtors to file as medical debtors irrespective of whether medical debts are actually driving the household to bankruptcy, the Medical Bankruptcy Fairness Act would essentially be providing relief from credit card debt rather than medical debts.[2] Given that the Act would allow not only medical filers, but also all other debtors, to file for bankruptcy under Chapter 7, I believe that the credit counseling requirement should be made mandatory even under the provisions of the Act. Filers with large debts, whether medical or other, would benefit from such counseling. While it might be an irritant to non-opportunistic debtors like Ms. Burns, overall the system would be better served by requiring such counseling for all debtors, rather than removing it for some and not others. This is particularly true since even filers with primarily medical debts are likely to have accumulated other debts, and these sessions might serve to help them manage their other debts better.

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[1] Marianne B. Culhane & Michaela M. White, *Taking the New Consumer Bankruptcy Model for a Test Drive: Means-Testing Real Chapter 7 Debtors*, 7 AM. BANKR. INST. L. REV. 27, 37–38 (1999); Ed Flynn & Gordon Bermant, *Bankruptcy by the Numbers: Chapter 7 Asset Cases*, AM. BANKR. INST. J., Dec. 2002–Jan. 2003

[2] http://weber.ucsd.edu/~miwhite/UIll-law-review--final.pdf

Response to Questions 3a and 3b.

I believe that the current system would be open to abuse and fraud if the Medical Bankruptcy Fairness Act were made into law. This could happen in the following ways:

A study of the distribution of bankruptcy filers by income in 2000-2002 showed that more than 85 percent of filers had annual incomes less than or equal to $48,000, with almost 60 percent earning between $24,000-$36,000.[3] This means that if the average filer spent about $2400-$4000 on medicines or medical care in any year, then they would qualify for a medical bankruptcy. This seems like a relatively low level of debt considering that the same study shows that credit card debts average approximately $20,000 for this group of low-income borrowers. In the worst case scenario, this could create perverse incentives for households since by accumulating a relatively lower level of medical debt, they could take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of their high credit card debts. In fact, it might even tempt households to accumulate other types of debt prior to the filing, since they are eligible for debt discharge under Chapter 7. Therefore, by allowing debtors to file as medical debtors irrespective of whether medical debts are actually driving the household to bankruptcy, the Medical Bankruptcy Fairness Act would essentially be providing relief from credit card debt rather than medical debts.[4]

The means test incorporated into the bankruptcy code in 2005 was designed to limit the use of Chapter 7 bankruptcy to those who truly cannot pay their debts. In effect, it limits the ability of high income filers to walk away from their debts when they have the ability to pay for them by forcing them into Chapter 13 bankruptcy. This increases efficiency and ensures that creditors get at least a minimum return on their debt. Doing away with the means test under the Medical Bankruptcy Fairness Act would allow high income individuals to walk away from not only their medical debts, but also other debts such as credit card debts. For instance, it is typically the case that families incurring high medical debts, especially due to job loss or other adverse events, also incur other debts, such as car loans, unpaid utility bills, credit card debts etc. If medical filers are no longer subject to means testing, then high income debtors would have an easier time walking away from their other dischargeable debts. In the study of bankruptcy filers cited earlier, those with incomes higher than $70,000 had average credit card debts of $42,000. Allowing this group to take advantage of the debt discharge provisions under Chapter 7 would hit creditors particularly hard. This is the exact situation that the 2005 bankruptcy reform tried to address. One possibility to avoid such a situation could be to set higher percentage of income thresholds for medical debt for higher income households, to allow eligibility for a Chapter 7 bankruptcy.

The high exemption limits also create incentives for debtors to act opportunistically. The incentive for debtors under these high exemption limits is to reallocate all wealth from non-exempt assets to exempt assets. For instance, if the homestead exemption were raised to $250,000 the individual would have an incentive to convert all non-housing assets to housing

[3] Marianne B. Culhane & Michaela M. White, *Taking the New Consumer Bankruptcy Model for a Test Drive: Means-Testing Real Chapter 7 Debtors*, 7 AM. BANKR. INST. L. REV. 27, 37–38 (1999); Ed Flynn & Gordon Bermant, *Bankruptcy by the Numbers: Chapter 7 Asset Cases*, AM. BANKR. INST. J., Dec. 2002–Jan. 2003

[4] http://weber.ucsd.edu/~miwhite/UIll-law-review--final.pdf

(say by using all available bank accounts to pay off the mortgage), so as to protect more of their income and wealth from the creditors.

All of these provisions would have an effect on the market for credit, and therefore might have adverse effects on exactly the debtors that the Act is trying to help. First, the Act does little, if anything at all, for the creditors in these medical transactions. As discussed in the previous two paragraphs, there could be potentially serious consequences for medical service providers if we make it easier for debtors to file for medical bankruptcy involving the discharge of all medical debts. In fact, research has shown that between 1994 and 2000, unsecured creditors received nothing in about 96 percent of Chapter 7 bankruptcy filings, and in most Chapter 13 cases, only mortgage creditors received anything at all.[5] These higher costs of bad debts will ultimately be passed on to consumers in the form of higher prices for care or poor delivery of care.

Second, there is now a fairly large volume of economics papers that discusses how high bankruptcy exemptions affect debtor behavior. Debtors value high exemptions because it provides them with consumption insurance by discharging some or all of their debts when a drop in income would otherwise have caused a drop in consumption. However, because higher exemptions for wealth and income make filing for bankruptcy more attractive, studies show that the number of filings increases when exemptions increase.[6] This adversely affects the market for credit. To insure against the probability of a bankruptcy filing, lenders raise interest rates or ration credit,[7] which harms debtors who repay as well as those who would like to borrow but are rejected.[8] Hence creditors alter behavior when faced with higher exemptions. This will ultimately impact debtors adversely.

Response to Question 4.

It is simply not worth anyone's while to comment on studies with 20 respondents. The same issues that I brought out in response to the medical foreclosures study, apply with even more force to this study. No results from such surveys have any meaning whatsoever.

Response to Question 5.

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[5] Stewart E. Sterk, *Asset Protection Trusts: Trust Law's Race to the Bottom?*, 85 CORNELL L. REV. 1035, 1036 (2000).

[6] Michelle J. White, *Personal Bankruptcy Under the 1978 Bankruptcy Code: An Economic Analysis*, 63 IND. L.J. 1, 45–46 (1987) (discussing data indicating that an increase in the bankruptcy exemption level corresponds with an increased bankruptcy filing rate).

[7] Reint Gropp, John Karl Scholz, & Michelle J. White, *Personal Bankruptcy and Credit Supply and Demand*, 112 Q.J. ECON. 217 (1997) (showing that higher exemption levels result in higher interest rates).

[8] The optimal exemption levels in bankruptcy are determined by trading off debtors' gain from having additional consumption insurance and better work incentives when exemption levels are higher against their losses from higher interest rates and reduced access to credit. For a formal model and simulations, see Michelle J. White, Personal Bankruptcy: Insurance, Work Effort, Opportunism and the Efficiency of the "Fresh Start," (May 2005) (unpublished manuscript, on file with author), *available at* http://www.econ.ucsd.edu/~miwhite/bankruptcy-theory-white.pdf, and Hung-Jen Wang & Michelle J. White, *An Optimal Personal Bankruptcy Procedure and Proposed Reforms*, 29 J. LEGAL STUD. 255, 265 (2000).

As I mentioned earlier, the problem with establishing causation in the kinds of survey analysis presented here arises because people who have already filed for bankruptcy are a selected group or sample who have problems managing not just their medical debts, but all other debts. The average credit card balance for bankruptcy filers is more than $20,000 while the average for all American families as shown by the Survey of Consumer Finances is about $4000-$5000. This suggests that this group includes people who are either financially irresponsible, or they have suffered other adverse events such as job loss or income loss which has caused them to file for bankruptcy. Hence asking this group questions about whether they had any medical debts that could have caused the filing is meaningless. The co-existence of medical debts with other debts is insufficient to establish causation.

SUBMISSIONS FOR THE RECORD

American Law & Economics Association Annual Meetings

Year 2004 *Paper* 28

Is the Bankruptcy Flag Binding? Access to Credit Markets for Post-Bankruptcy Households

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Is the Bankruptcy Flag Binding? Access to Credit Markets for Post-Bankruptcy Households

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Abstract

Legally, a bankruptcy flag can appear on a bankruptcy filer's credit report for up to ten years after the filing. This bankruptcy flag affects an individual's credit score, and therefore the individual's access to credit. In this paper, we test whether the bankruptcy flag is a binding constraint in two ways. First, we test whether the consumption of bankruptcy filers exhibits excess sensitivity to changes in income, which is a traditional method by economists to test for borrowing constraints. Second, we use an explicit question on whether a household was turned down for a mortgage loan or discouraged from applying for a mortgage loan.

Using the Panel Study of Income Dynamics (PSID), our results indicate that post-bankruptcy consumers exhibit excess sensitivity likely due to the bankruptcy flag. Preliminary results also suggest that post-bankruptcy households are more likely to be denied a mortgage, using both the PSID and the Survey of Consumer Finances (SCF).

All views expressed in this paper are those of the author and do not reflect the views or policies of the Bureau of Labor Statistics (BLS) or the views of other BLS staff members.

I. Introduction

Legally, a bankruptcy filing can appear on an individual's credit report for up to ten years. Musto (2004) finds evidence that the bankruptcy flag does influence access to unsecured credit. Using a panel of credit card data, Musto follows individuals before, during, and after the bankruptcy flag is removed from their credit report. He finds that those households with relatively good credit scores enjoy significantly more access to credit when the bankruptcy flag is removed, indicating that the bankruptcy flag decreased access to credit for the ten year span.

In this paper, we complement the research of Musto by examining how filing for personal bankruptcy affects access to credit in the ten years after bankruptcy. In 1996, the Panel Study of Income Dynamics (PSID) included questions on whether individuals ever filed for bankruptcy. And, in the 1998 and 2001 Survey of Consumer Finances (SCF), households were asked whether they ever filed for bankruptcy. Using two different methods, we use this information to examine the effects of bankruptcy on access to credit.

First, in the standard rational expectations permanent-income hypothesis (REPIH) model, consumption growth should not depend on idiosyncratic variables, such as lagged household income. However, in the presence of borrowing constraints, such as those imposed by filing for personal bankruptcy, consumption may exhibit excess sensitivity. We use this insight to test whether the bankruptcy flag is a binding borrowing constraint, using the PSID. Empirically, we find that post-bankruptcy households do exhibit excess sensitivity to lagged income, which suggests that the bankruptcy flag affects access to credit. Further, when the flag is removed from the credit report, consumption of these households no longer exhibits excess sensitivity.

Second, we use a more direct test of whether the flag affects access to credit. For this test, we use both the PSID and the SCF. Both surveys ask questions about households being turned down for loans. In both data sets, we find that households are more likely to be turned down for a loan if they have the bankruptcy flag on their credit report.

II. Personal bankruptcy background information

A. Chapter 7 and chapter 13

An individual filing for bankruptcy chooses between chapter 7 and chapter 13. Of the 1.56 million personal bankruptcy filings in 2002, 1.10 million (70.4 percent) were filed under chapter 7. Under chapter 7, the debtor forfeits all assets exceeding the exemption levels to the Bankruptcy Court. A bankruptcy trustee sells the non-exempt assets and distributes the money to the creditors. In return, a chapter 7 filing discharges most unsecured debts. Secured debts are discharged only if the debtor forfeits the collateral.

The other option when filing for personal bankruptcy is chapter 13. Filers do not turn over any assets to the bankruptcy court but instead propose a repayment plan for a portion of the outstanding debts. Essentially, chapter 13 filers put themselves on a strict budget during this repayment plan. If the repayment plan is successfully completed, the filer receives a discharge of some of the unsecured debts. If the plan is not completed, the filer does not receive the discharge. The de facto rule regarding repayment is that chapter 13 filers must repay at least as much as they would have repaid if they had filed under chapter 7, but chapter 13 filers do not have to turn over any assets to the bankruptcy court. Because of the repayment plan, chapter 13 is less popular than chapter 7.

B. Affect of bankruptcy on credit history

Regardless of chapter choice, the bankruptcy filing appears on an individual's credit history for ten years (Fair Credit Reporting Act; *FCRA Section 605 (a)(1)*). Once the ten-year window passes, the credit bureaus can no longer report the bankruptcy filing on an individual's credit report. Bankruptcy is unique in this aspect because all other adverse events (e.g., civil judgments and tax liens) can appear on a credit history for only seven years (*FCRA Section 605 (a)*).

Interestingly, just because the bankruptcy information does not appear on the credit report after ten years, this does not mean that the information is lost. If an individual has an existing relationship with a creditor within the ten-year post-bankruptcy window, the creditor can still maintain its own record of the bankruptcy filing after the flag is removed from the credit report. The FCRA act only applies to credit

bureaus; it does not apply to creditors that obtained this information about the bankruptcy filing during the ten-year window. Existing creditors presumably continue to use the bankruptcy information even after it is removed from the credit report.

The other relevant feature of bankruptcy law is that a filer must wait six years after the discharge of debts before he can legally file for bankruptcy again. While the individual may default on debt during this time by not repaying bills, creditors can take legal action to garnish wages or repossess assets. Consequently, this feature of bankruptcy law may increase the willingness of some creditors to lend to post-bankruptcy individuals during the first six years after the discharge of debts. Musto (2004) finds that post-bankruptcy individuals have less access to credit, but they do have access to limited credit lines.

Combined, there are two countervailing forces. First, the bankruptcy flag on the credit report decreases access to credit by signaling a poor credit risk. Second, the fact that the individual cannot file for bankruptcy until six years after the previous discharge may increase access to credit. Overall, the net effect would still be a decrease in access as shown by Musto (2004), but it might be more than it would have been if bankruptcy filers were allowed to file for bankruptcy again at any point after the initial filing.

III. Data

A. Panel Study of Income Dynamics

For most of the empirical work in the paper, we use the Panel Study of Income Dynamics (PSID), which is a longitudinal household survey that began in 1968. In addition to having longitudinal information on expenditures, the 1996 wave of the PSID includes the necessary information about any bankruptcy filings. In the 1996 wave, all households were asked whether they ever filed for bankruptcy. If they did file, they were asked under which chapter they filed and in what year(s) they filed. Because the bankruptcy information is only available in the 1996 wave, households not in the 1996 wave of the PSID are excluded from our sample.

There are two other important aspects of the PSID data. First, the PSID includes expenditure information, which we use to test for excess sensitivity. The PSID includes information regarding food eaten out, food eaten at home, and food stamp usage. We sum these components to create one food

expenditure variable. Since the 1988 and 1989 waves of the PSID do not include the food questions, we exclude these years from our sample.[1] Second, the 1996 wave of the PSID also includes questions on whether households were ever turned down for a home loan. Homeowners were asked whether they took steps to apply for a second mortgage or other secured line of credit against their home. Renters were asked whether they ever took steps to apply for a home loan. For those that did take steps for either a second loan or a first mortgage, they were also asked whether they were discouraged from borrowing and why they were turned down for the loan. We classify any household that took steps to apply for a loan but did not receive a home loan as being constrained, regardless of the reason they were turned down.

Summary statistics for the main variables from the PSID are presented in Table 1. All dollar-denominated variables are in real, 1996 dollars. The summary statistics are presented by filing status. The first group, post-bankruptcy constrained, is our group of constrained bankruptcy filers that are within the ten-year window after they filed for bankruptcy. There are 325 households, with 1,478 observations (household years). The second group, the pre-bankruptcy households, includes 159 households in the five years before the household filed for bankruptcy.[2] Finally, the third group is the non-filers, which includes the 5,937 households (28,500 observations) that did not file for bankruptcy in the PSID.

In terms of demographics, the summary statistics follow patterns seen in the bankruptcy literature (Fay, Hurst, and White, 2002). Bankruptcy filers are younger and slightly more likely to be divorced than non-filers. And, there is little difference in race and education between filers and non-filers.

B. The Survey of Consumer Finances

When conducting the second test, we also use the Survey of Consumer Finances (SCF) from 1998 and 2001. The SCF is a cross-sectional survey sponsored every three years by the Board of Governors of the Federal Reserve System. The SCF provides detailed information on the income, assets, liabilities,

[1] The timing of the food questions is not altogether clear. Generally, the PSID questions are asked in March to June of the survey year, and the food at home and food away questions refer to how much is purchased in an average week. Zeldes (1989) assumes that information asked in year t is for year t consumption, while others have assumed that year t questions refer to year t-1 consumption. In this paper, we follow the Zeldes interpretation.

credit experiences, and demographic characteristics of U.S. households. Beginning in 1998, the SCF began asking questions regarding personal bankruptcy. We use this bankruptcy information and questions regarding credit access to conduct the second test. The credit questions in the SCF are very similar to the ones used in the PSID. One difference, however, is that the SCF includes all types of loans, not just mortgage related loans. Importantly, the SCF identifies the type of loan the household applied for but did not receive. Consequently, we can an identical specification as the one used in the PSID, and we can use a broader definition of loans as well.

IV. Results

A. Test for Excess Sensitivity

To begin, we present results testing for the excess sensitivity of consumption. This test is derived from the economics literature on liquidity constraints (Zeldes 1989). If households are liquidity constrained or borrowing constrained, then the household is unable to borrow in anticipation of a positive income shock. Unable to borrow, the household will not be able to consume the optimal amount. When a positive income shock actually occurs, consumption will jump up as well. This jump in consumption is the excess sensitivity of consumption. If there were no borrowing constraint, the household would have borrowed money in anticipation of the positive shock. And, at the time of the shock, consumption growth would not be sensitive to the predictable change in income.

To test for the presence of excess sensitivity, the estimated equation takes the form:

$$\Delta \ln c_{i,t+1} = \alpha_1 + \beta_1' X_{i,t+1} + \gamma_1 \ln y_{it} + \varepsilon_{it}^1 \quad \text{if } B_{it} = 1 \qquad (1)$$

where B_{it} denotes whether the household is in the ten years after a filing; the dependent variable is the growth in food consumption from t to $t+1$, the vector $X_{i,t+1}$ contains household level information known at time $t+1$ that may influence tastes or preferences. Previous work has included information such as the age of the household head, and the change in family size. Finally, y_{it} equals household income in year t.

[2] In the data, there are 325 post-bankruptcy households and 159 pre-bankruptcy households. The remaining households filed for bankruptcy before 1986 but after 1977, which put them in the ten-year post-bankruptcy window

Under the standard model of Hall (1978), variables in the consumers' information set should be uncorrelated with consumption growth. If households are not liquidity constrained, the coefficient on the log of lagged disposable income (γ_1) should be statistically insignificant. However, if post-bankruptcy households face binding liquidity constraints, then γ_1 should be negative and statistically significant.

Table 3 provides the parameter estimates of the Euler equation for bankruptcy filers that are within ten years of filing. We perform pooled OLS in each specification with year dummy variables. The year dummy variables control for aggregate economic fluctuations, which could be a significant problem when the time span of the panel is relatively short, because there may be common components in the forecast errors across individuals. Our sample contains ten years of data (1985-1987 and 1990-1996), which is longer than most previous work and increases the likelihood that aggregate effects are averaged out. In fact, we only find a marginal difference between the point estimates from a model with and without time effects and the conclusions are unchanged.

To compare our results to some of the previous literature, all three columns represent specifications similar to those used in the previous research. Column one represents the specification proposed in Zeldes (1989). In addition to the lag of income, this specification contains: the age of the household head, age squared, and the growth in food needs. Column two represents the specification proposed by Jappelli, Pischke, and Souleles (1998) and uses the change in the number of adults in the household, and the change in the number of children in the household in place of the growth of food needs.

As mentioned earlier, the coefficient on lagged income is the parameter of interest. We do find evidence of excess sensitivity in column one and column two. This suggests that post-bankruptcy filers exhibit excess sensitivity to income, meaning that the bankruptcy flag is binding.

A well documented fact is that excess sensitivity can arise from several competing alternatives. (see Hall and Mishkin 1987; and, Garcia et al. 1997). Specifically, behavior such as precautionary saving and myopia can generate excess sensitivity (see Shea 1995, and Garcia et al. 1997). Households with a

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but that also means that their pre-bankruptcy period is not part of our sample.

precautionary motive (or buffer-stock savers) have a target wealth-to-income ratio and adjust consumption and savings to maintain this target ratio (Carroll 1997). If there is a precautionary motive to savings, the expected variance of consumption growth affects consumption growth (Jappelli and Pistaferri 2000). A household with low income relative to permanent income will have a high expected variance and higher consumption growth. Without a measure of the expected variance, lagged income will be negatively correlated with consumption growth, which could explain the pattern seen in the first three columns of Table 3.

A myopic or rule-of-thumb consumer has a constant marginal propensity to consume, which violates the REPIH (Garcia et al., 1997). Myopia differs from liquidity constraints, because a liquidity or borrowing constrained consumer saves in anticipation of a negative income shock and therefore smooths expected decreases in income. A liquidity constrained consumer, however, cannot borrow in anticipation of a positive income shock. This suggests that a liquidity constrained household is excessively sensitive only to predicted increases in income. Alternatively, a myopic consumer is excessively sensitive to both predicted increases and predicted decreases in income.

We believe that households that have filed for bankruptcy are generally not precautionary savers, which seems like a reasonable assumption; by filing for bankruptcy, these households have shown that they are not likely to be saving to insulate consumption against negative income shocks. However, we would like to rule out formally the possibility that they are myopic consumers. If liquidity constraints are the source of sensitivity, post-bankruptcy households should exhibit sensitivity to predicted income increases but not to predicted income decreases. Under myopic consumption, the household should respond symmetrically to both increases and decreases in predicted income.

To test whether post-bankruptcy households are liquidity constrained or myopic, there is a two stage process. In the first stage, predicted income growth must be estimated. To estimate predicted income growth, we estimate the following equation by pooled OLS:

$$\Delta y_{t+1} = \varphi + \sum_{j=t-2}^{t} \eta \Delta y_j + \theta \Delta(weeks_{t+1}) + \beta X_{t+1} + \tau_{t+1} + \Delta u_{t+1}. \qquad (2)$$

We use the estimated coefficients from this specification to obtain values for predicted income growth ($\Delta\hat{y}_{t+1}^{+}$) and predicted income decline ($\Delta\hat{y}_{t+1}^{-}$). The estimated coefficients are presented in Appendix Table A1. This specification for the change in income follows Altonji and Siow (1987) in using lags of income growth to predict current income growth.

In Table 3, column three examines the possible asymmetry in excess sensitivity. The results confirm that the existence of excess sensitivity is due to liquidity constraints and not myopia for our sample of post-bankruptcy households. While the point estimate on the negative income change is statistically insignificant, the bankrupt households are sensitive to the positive income changes, as expected if they are liquidity constrained and not myopic.

An additional concern in our analysis is that our sample of post-bankruptcy households appears liquidity constrained for some reason other than or in addition to the bankruptcy flag on their credit report. Can we attribute our results solely to the post-bankruptcy flag? Or, are these households constrained in all periods for other reasons, such as low assets? Indeed, the behavior of post-bankruptcy households may be observationally equivalent to low-asset households. While we cannot definitively state whether the results in Table 3 are due to the bankruptcy flag or something else, we attempt to address this issue. We test whether households that filed for bankruptcy display excess sensitivity in the five years before filing for bankruptcy and in the time span from eleven to fifteen years after the following (representing the time frame immediately after the flag is removed). Excess sensitivity in either of these time periods suggests that the bankruptcy flag is not the source of the excess sensitivity.

Column (1) in Table 4 presents the point estimates on lagged income for both exercises, and column (2) uses the predicted changes in income. The rows correspond to the pre-bankruptcy and post-flag periods respectively. There is no evidence of excess sensitivity in either test or for either group. The evidence presented in Tables 3 and 4 supports the proposition that households in the post-bankruptcy period are liquidity constrained. This result is robust to various specifications and tests of competing hypothesis. Generally, post-bankruptcy households exhibit stronger excess sensitivity than other groups found to be constrained by the previous literature (see Zeldes 1989 and Jappelli et al 1997).

B. Empirical test for access to credit

While the test for excess sensitivity is a preferred test of economists, the PSID and SCF allow a more direct method to test whether the bankruptcy flag affects access to credit. This test uses variables identifying whether households were turned down for a loan or discouraged from applying for a loan. In this test, we examine whether the bankruptcy flag increases the probability a household is turned down for a loan. To conduct this test, we use both the PSID and SCF.

In 1996, the PSID asked households whether they took steps to apply for a home loan (a second mortgage or home equity line for homeowners and a first mortgage for renters). If the household did take steps, they were also asked whether they received the loan. As our dependent variable, we define a variable that equals one if the household was not given the loan, and zero otherwise.

In every survey year, the SCF asks whether households were turned down for a loan and whether they were discouraged from applying. The biggest advantage of the SCF is that the loan questions refer to all types of loans, not just home loans. The biggest disadvantage of the SCF is that the year the household was applied for the loan is not known. The questions only refer to loans within the last five years, without specifying an exact year.

The hypothesis is that the presence of the bankruptcy flag should make households more likely to be turned down for a loan. Not conditioning on any factors except bankruptcy status, Table 2A presents the percentage of households that were denied access to credit. In the PSID, 3.1 percent of all households were denied access to a mortgage loan. In the SCF, 3.6 percent were denied access to a mortgage loan, while over 23 percent were turned down (or discouraged) for any type of loan. As expected, in both the PSID and SCF a higher percentage of post-bankruptcy households were denied access to secured loans. For mortgage loans, 5.1 percent and 10.2 percent of bankruptcy filers one to five years after bankruptcy were denied access in the PSID and SCF, respectively. Six to ten years after bankruptcy, the percentages are about the same. The largest difference between the two data sets is in the years after the bankruptcy flag is removed from the credit report. In the PSID, only 1.4 percent were denied a home loan, while 10.9

percent were in the SCF. This could be because of slightly different definitions in how the PSID and SCF define the loan questions, but that alone should not account for the large difference.

Table 2B provides some insight into why these households were denied access in the PSID. Of the households that took steps to apply but were discouraged from continuing, almost 13 percent of households listed credit history problems as one of the reasons they were denied access to credit.

Table 5 presents the results, using the probit method for this test. The dependent variable again equals one if the household was turned down for a loan or discouraged from applying. In the PSID, the loan only refers to a mortgage loan or home equity loan. In the SCF, we present two different specifications. The first follows the PSID definition and only uses mortgage and other home loans. The second includes all loans.

The key independent variables are three variables for the bankruptcy flag. The first variable equals one if the household filed for bankruptcy in the previous five years. The second variable equals one if the household filed six to ten years ago. Finally, the last key variable equals one if the household filed for bankruptcy eleven to fifteen years ago. Again, we want to determine whether it is the bankruptcy flag that might be affecting access to credit, not some other variable that might be correlated with the bankruptcy flag.

The other variables in the specification include variables that may affect access to credit and are similar to work by Cox and Jappelli (1993), which looked at access to credit using the Survey of Consumer Finances. The variables are: income, net worth, education, age, marital status, race, family size, employment status, and region dummy variables. The SCF does not include the region variables, so we exclude these dummy variables from the SCF results.

The results in Table 5 closely match what is seen in Table 2A. For the PSID, the coefficients for an active bankruptcy flag are positive and significant, indicating that the presence of the flag increases the probability of being turned down for a loan. Importantly, the coefficient for a bankruptcy filing more than ten years ago is statistically insignificant. For the SCF, all three coefficients are statistically significant, suggesting that filing for bankruptcy still affects access to credit after the bankruptcy flag is

removed from the credit report. In part, this effect might be due to the timing of the bankruptcy and loan questions in the SCF. We conducted sensitivity analysis regarding the timing of these variables, and the results were similar. These results are not presented here but will be in future versions of this paper. In part, it may also be the fact that bankruptcy filers are more likely to be discouraged and not actually apply. This is another issue to be addressed in future versions.

Comparing the results with only mortgage-type loans in the SCF and all loans in the SCF, the results look similar. The biggest difference is that income and net worth are significant predictors in the all loans specification but not the mortgage specification.

In results not presented here, we wanted to determine whether the penalty for filing for bankruptcy has changed over time. Ultimately, we would like to compare the PSID results from 1994 to the SCF results from 1998 and 2001, but we are not confident in our ability to do this yet. However, we can compare 1998 and 2001 in the SCF. To accomplish this, we interact a year dummy variable with the three bankruptcy variables. For the years when the bankruptcy flag is on the credit report, we fail to reject the hypothesis that the coefficients changed over time. Not surprisingly, the penalty does not seem to have changed between 1998 and 2001. It may take additional years of data to see whether there was a change in the penalty.

Finally, we are also concerned that non-filers may not be the proper control group in these regressions. Maybe the relevant group is not those households that never filed, but households that filed for bankruptcy but do not have the flag currently on the credit report. If we restrict the SCF regressions to just those that ever filed for bankruptcy, the coefficient on the two dummy variables for the years when the bankruptcy flag is on the credit report remain positive and statistically significant.

This latter work is still preliminary, and there are a few improvements that are underway. First, there may be an application bias, meaning that bankrupt households may be less likely to apply for a loan; there may be selection into who applies for a loan. We will use questions in the PSID and SCF to determine whether bankruptcy filers are less likely to apply for a loan. Second, there are several improvements on-going with the SCF data, as described above. We are also estimating the size of the

borrowing gap using the SCF. In essence, we address the question: how much more would those households with a bankruptcy flag on their credit report like to borrow? This gets at whether the flag limits access to credit, and it gets at the severity of the punishment.

VI. Conclusions

The objective of this paper was to test whether the bankruptcy flag, which appears on the credit report for up to ten years after filing, limits access to credit. We find evidence that the flag is binding, using two distinct tests. The first test suggests that the consumption of bankruptcy filers is sensitive to income, which indicates that the bankruptcy flag does restrict access to credit. In the second test, the results suggest that the bankruptcy flag increases the probability a household is denied access to credit.

Our results complement the findings in Musto (2004) by providing another test of whether bankruptcy affects access to credit. There is on-going work with this second test that will hopefully address some additional interesting questions, including: Has the penalty from filing decreased or increased over time?

References

Administrative Office of the United States Courts. *Bankruptcy Basics*. (1998).

Altonji, Joseph G., and Aloysius Siow. "Testing the Response of Consumption to Income Changes with (Noisy) Panel Data," *Quarterly Journal of Economics* 102(2) (1987): 293-328.

Carroll, Christopher D., "Buffer-Stock Saving and the Life Cycle/Permanent Income Hypothesis," *Quarterly Journal of Economics* 112(1) (1997): 1-55.

Cox, Donald, and Tullio Jappelli, "The Effect of Borrowing Constraints on Consumer Liabilities," *Journal of Money, Credit, and Banking* 25(2) (1993): 197-213.

Fay, Scott, Erik Hurst, and Michelle J. White, "The Household Bankruptcy Decision." *American Economic Review* 92(3) (June 2002): 706-718.

Garcia, Rene, Annamaria Lusardi, and Serena Ng. "Excess Sensitivity and Asymmetries in Consumption: An Empirical Investigation," *Journal of Money, Credit, and Banking* 29(2): 1997.

Hall, Robert E. "Stochastic Implications of the Life Cycle-Permanent Income Hypothesis: Theory and Evidence," *Journal of Political Economy* 86: 1978.

Hall, Robert E., and Frederic S Mishkin. "The Sensitivity of Consumption to Transitory Income: Estimates from Panel Data on Households," *Econometrica* 50(2): 1982.

Jappelli, Tullio, Jorn-Steffen Pischke, and Nicholas S. Souleles. "Testing for Liquidity Constraints in Euler Equations with Complementary Data Sources," *Review of Economics and Statistics* 1998.

Jappelli, Tullio, and Luigi Pistaferri. "Using Subjective Income Expectations to Test for Excess Sensitivity of Consumption to Predicted Income Growth," *European Economic Review* 44 (2000).

Musto, David K. "The Effect of Personal Bankruptcy on Credit Access: Evidence from a Panel Database of Credit Reports." *Journal of Business* 77(4) (2004).

Shea, John. "Myopia, Liquidity Constraints, and Aggregate Consumption: A Simple Test," *Journal of Money, Credit, and Banking* 27(3) (1995): 798-805.

White, Michelle J., "Why Don't More Households File for Bankruptcy?" *Journal of Law, Economics, and Organization* 14(2) (1998): 205-231.

Zeldes, Stephen P. "Consumption and Liquidity Constraints: An Empirical Investigation," *Journal of Political Economy* 97(2): 1989.

Table 1: Summary Statistics by bankruptcy status (1985-1995)

	Post-bankruptcy (≤ 10 years after filing)	Pre-bankruptcy (≤ 5 years before filing)	Never filed
Income and home equity ($)			
Total income	38,792	40,931	49,770
	(25,746)	(28,095)	(52,240)
Financial income	88	107	32,530
	(615)	(681)	(752,469)
Consumption ($)			
Total food	5,796	5,451	5,629
	(3,185)	(3,001)	(3,854)
Food needs	12,671	8,801	11,404
	(5,204)	(6,183)	(5,083)
Family Characteristics			
Age of household head	39.7	37.5	45.0
Family size	3.2	3.2	2.9
Own home	0.472	0.515	0.646
Married	0.579	0.591	0.618
Single	0.108	0.108	0.148
Divorced/widowed	0.313	0.301	0.234
White	0.630	0.597	0.671
Black	0.338	0.383	0.310
Other race	0.032	0.020	0.019
High school dropout	0.229	0.173	0.233
High school graduate	0.410	0.454	0.339
Some college (no degree)	0.262	0.298	0.203
College graduate	0.099	0.075	0.225
Number of observations	1,478	342	28,500
Number of households	325	159	5,937

Notes: All data come from the Panel Study of Income Dynamics (1985-1995), and the non-food items are in real, 1996 dollars using the CPI-U-RS. Total food and food needs are in real, 1996 dollars using the item index for food. Standard deviations are in parentheses.

Table 2A: Percent denied access for loan by filing status – PSID and SCF

	PSID % denied Mortgage loans	SCF % denied Mortgage loans	SCF % denied All loans
All households	3.1	3.6	23.2
Filers one to five years after bankruptcy	5.1	10.2	66.6
Filers: six to ten years after	4.5	9.6	61.0
Filers: eleven to fifteen years after	1.4	10.9	52.6
Non-filers	2.9	3.1	20.5

Table 2B: Reason turned down for loan – PSID only

	% given as reason (may give more than one answer)
Did not apply for loan	
Interest rate too high	3.7
Down payment too high	7.3
Closing costs too high	1.0
Other	86.0
Turned down for loan	
Credit history problems	12.9
Too much debt	2.0
Income not high enough (or stable enough)	9.9
Couldn't make down payment	5.0
Withdrew loan on own	12.9
Other	57.4

Table 3: Euler equation estimates (post-bankruptcy households)

	(1)	(2)	(3)
	Post-bankruptcy households (≤ 10 years after filing)		
y_t	-0.0243*	-0.0228*	---
	(0.0129)	(0.0133)	
$\Delta\hat{y}_{t+1}+$	---	---	0.0900*
			(0.0497)
$\Delta\hat{y}_{t+1}-$	---	---	0.0404
			(0.0567)
Age_{t+1}	0.0032	0.0042	0.0015
	(0.0055)	(0.0053)	(0.0052)
Age_{t+1} squared/100	-0.0062	-0.0069	-0.0040
	(0.0060)	(0.0059)	(0.0058)
Δ adults$_{t+1}$	---	0.1613***	0.1544***
		(0.0308)	(0.0307)
Δ children$_{t+1}$	---	0.1457***	0.1416***
		(0.0283)	(0.0285)
Δ Annual Food Needs$_{t+1}$	0.3683***	--	---
	(0.1205)		
Constant	0.1743	0.1342	-0.0506
	(0.1621)	(0.1589)	(0.1181)
Observations	1,478		

Notes: Robust standard errors are presented in parentheses. All data use the PSID (1985-1996). (***), (**), and (*) represent significance at the 1, 5 and 10 percentiles respectively. The estimates presented in the table represent a model with year dummy variables. The dependent variable equals the log change in food expenditures. The predicted change in incomes ($\Delta\hat{y}+$ and $\Delta\hat{y}-$) are predicted using the specification in Appendix Table A1.

Table 4: Euler equation estimates (post-bankruptcy households and pre-bankruptcy households)

		(1)	(2)	
		y_t	$\Delta\hat{y}_{t+1}+$	$\Delta\hat{y}_{t+1}-$
(A)	*Pre-bankruptcy flag households* (1 to 5 years before filing) (n = 223)	-0.0058 (0.0317)	---	---
		---	0.0956 (0.1246)	0.2808** (0.1256)
(B)	*Post-bankruptcy flag households* (11 to 15 years after filing) (n = 342)	-0.0450 (0.0381)	---	---
		---	-0.1212 (0.2572)	0.2709*** (0.0573)

Notes: Robust standard errors are presented in parentheses. Both specification (1) and (2) include age, age squared, the change in the number of adults, the change in the number of children, year dummy variables, and a constant. All data use the PSID (1985-1996). (***), (**), and (*) represent significance at the 1, 5 and 10 percentiles respectively. The dependent variable equals the log change in food expenditures. The predicted change in incomes ($\Delta\hat{y}+$ and $\Delta\hat{y}-$) are predicted using the specification in Appendix Table A1.

Table 5: Probability of being turned down for a loan – PSID and SCF

	PSID	***SCF***	***SCF***
	Mortgage loans	*Mortgage loans*	*All loans*
	Coefficient (std. error)	*Coefficient (std. error)*	*Coefficient (std. error)*
Filed in last five years	0.3334*	0.4203***	0.9738***
	(0.1997)	(0.1262)	(0.0917)
Filed six to ten years ago	0.5857*	0.4854***	1.0504***
	(0.3125)	(0.1629)	(0.1341
Filed eleven to fifteen years ago	0.1286	0.5337***	0.7795***
	(0.4033)	(0.1534)	(0.1160)
Income	-9.37e-07	-5.06e-08	-9.38e-07***
	(1.18e-06)	(1.48e-07)	(3.59e-07)
Net worth	-2.59e-07	-1.79e-08	-4.63e-08*
	(2.94e-07)	(1.88e-08)	(2.69e-08)
High school dropout	-0.2941*	0.0451	0.2840***
	(0.1759)	(0.1099)	(0.0635)
Graduated high school	-0.0719	0.0773	0.0923*
	(0.1759)	(0.0804)	(0.0494)
Some college	0.0969	0.1569*	0.2712***
	(0.1308)	(0.0908)	(0.0542)
Age	0.0118	0.0275*	-0.0109
	(0.0333)	(0.0163)	(0.0081)
Age squared	-0.0007	-0.0004**	-0.0002**
	(0.0004)	(0.0002)	(0.0001)
Married	0.0463	0.0677	-0.2374***
	(0.1204)	(0.0770)	(0.0459)
Black	0.1684	0.0787	0.4038***
	(0.1344)	(0.0966)	(0.0566)
Family size	-0.0747**	0.0726***	0.0577***
	(0.0395)	(0.0224)	(0.0149)
Whether employed	0.1663	-0.1907**	-0.0736
	(0.2052)	(0.0978)	(0.0567)
Region dummy variables	YES	NO	NO
R-squared	0.1536	0.0593	0.1813
n	6,402	8,679	8,679

Notes: For the PSID results, robust standard errors are presented in parentheses. The PSID data is from (1991-1995). The SCF data are from 1998 and 2001.
(***), (**), and (*) represent significance at the 1, 5 and 10 percentiles respectively.

Appendix Table A1: Predicted change in income (Δy_{t+1})

	Coefficient (std. error)
Δy_t	-0.5394***
	(0.0161)
Δy_{t-1}	-0.2870***
	(0.0151)
Δy_{t-2}	-0.1480***
	(0.0111)
Δ Weeks worked$_{t+1}$	0.0071***
	(0.0004)
Age$_{t+1}$	0.0050***
	(0.0014)
Age squared$_{t+1}$	-6.4e-05***
	(1.3e-06)
Δ Adults$_{t+1}$	0.1426***
	(0.0095)
Δ Children$_{t+1}$	0.0451***
	(0.0106)
Year dummy variables	YES
R-squared	0.2647

Notes: Robust standard errors are presented in parentheses. All data use the PSID (1985-1996). (***), (**), and (*) represent significance at the 1, 5 and 10 percentiles respectively. The dependent variable equals the log change in income between t+1 and t (see the data appendix).

Session Number: Parallel Session 8D
Time: Friday, August 29, PM

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Paper Prepared for the 30th General Conference of
The International Association for Research in Income and Wealth

Portoroz, Slovenia, August 24-30, 2008

Health Insurance, Household Debt, and Inequality: Evidence from the Survey of Consumer Finances

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Introduction[1]

An extensive literature spanning several disciplines has established the correlation between health and a variety of measures of socioeconomic status.[2] This paper complements this literature by examining the relationships between health status, health insurance, medical debt, and household wealth in data from the Survey of Consumer Finances (SCF). The SCF is widely regarded as a key source of information on the balance sheets of U.S. families, but comparatively little research has taken advantage of health-related data in the SCF. Using these data, I examine how factors that may leave households vulnerable to medical expenditure shocks—poor health and lack of health insurance—vary with household characteristics and how these factors are correlated with indicators of financial distress, such as delinquency on debt payments. By pooling data across 15 years, I am able to assess how rates of health insurance coverage, health status, and, for uninsured households, reported reasons for not having health insurance coverage have changed over time.

I also take advantage of the SCF's detailed information on household debts and focus particular attention on the relative prominence of debt owed for medical expenditures on the household balance sheet. Further, the paper provides evidence on the importance of medical concerns in households' finances by examining information on families' motives for savings, anticipated expenses, and reasons for income fluctuations. The paper concludes with a brief discussion of the potential implications of these descriptive findings and, in particular, how estimates of inequality based on the distribution of wealth or income alone may differ from those

[1] The views in this paper are mine alone and not necessarily those of the Board of Governors or its staff. This draft is preliminary and incomplete. Please do not cite or circulate without permission of the author.
[2] Recent contributions include Adams *et al* (2003), Deaton (2002), Hurd and Kapteyn (2001), Smith (1999, 2004) and Wenzlow *et al* (2004); see also the references in each of these, particularly to contributions from non-economists.

using a broader measure of inequality that additionally encompasses health-related measures of well-being such as insurance coverage.

It is difficult to isolate the causal mechanisms underlying the observed correlations between, say, self-reported health and socioeconomic status (SES). The "health-SES gradient" may reflect a wide array of influences, including potential linkages by which SES affects health, routes by which health status affects SES, and correlation of both health and wealth with unmeasured factors. The determinants of health insurance coverage, medical debt, and health status are likely similarly complex and inter-related. Thus, the initial results presented here are intended as descriptive and take advantage of the rich and nationally representative data in the SCF—including a number of medical- and health-related measures not generally available in other data sources—to establish basic facts and to highlight patterns in health indicators, insurance coverage, indebtedness, and financial vulnerability across households.

Data

The analysis uses data from the 1989 through 2004 Surveys of Consumer Finances (SCF). The SCF provides the most comprehensive and highest quality wealth data for U.S. households and has been conducted by the Board of Governors of the Federal Reserve System every three years since 1983.[3] Since the 1989 survey, the SCF has utilized a consistent dual-frame sample design with both a standard, geographically based random sample and a list sample; the list sample draws on statistical records derived from tax returns to oversample households that are likely to be wealthy (Kennickell, 2001). This design yields efficient measurement of both widely held types of assets and debts, such as cars and car loans, and

[3] Bucks, Kennickell, and Moore (2006) provide an overview of results from the 2004 SCF and additional information about the survey.

narrowly held wealth components, such as private businesses. In addition, information available for both respondents and non-respondents in the list sample provides a means of adjusting for differential rates of non-response, which tend to increase with income and wealth (Kennickell, 2007). Non-response adjusted weights are used throughout the paper so that estimates are representative of the overall U.S. household population (Kennickell and Woodburn, 1999).

The SCF includes detailed data on households' assets and liabilities as well as information on income, demographics, expectations and attitudes, use of financial institutions, current and past employment, and pensions. In addition, the SCF collects information on the health insurance status of individuals who live in the household and self-reported assessments of health for the household head and, in the case of couples, his or her spouse or partner. Of particular interest to this study, for nearly all debts, the survey asks about the purpose for which the money was borrowed and the type of institution that made the loan. These two pieces of information are key to identifying "medical debt" analyzed below.

Medical debt is defined as debt for which either: i) the loan purpose was "Medical/ dental/veterinary expenses; attorney's fees" and for which the lender was not reported to be a lawyer, or: ii) debt owed to a "doctor or hospital; dentist; veterinarian". Under this definition, medical debt may appear in several categories of loans in the SCF, namely, second mortgages, home equity loans, lines of credit, and "other loans." The "other loan" category captures non-mortgage installment loans taken out for a reason other than educational expenses or the purchase of a vehicle (which are recorded elsewhere in the survey) and includes outstanding bills that are more than 30 days past due.

This measure of medical debt may understate the actual fraction of household debt attributable to medical expenditures for two reasons. First, although respondents are generally

reminded to include medical bills as well as similar loans when asked about "other loans," it is possible that some SCF respondents may not consider outstanding bills to service providers as loans and consequently may not report them.[4] Second, it is not possible to identify the types of debt charged to credit cards, so outstanding medical debt owed on credit cards is excluded. Nonetheless, by calculating the amount of household debt owed for medical purposes, the paper provides a rough—albeit likely conservative—estimate of how much aggregate consumer debt statistics, which do not capture debts owed to service providers, might change if this type of debt were included in the aggregate estimate.

To my knowledge, only a handful of studies have examined the association between wealth, on the one hand, and health indicators or health insurance status, on the other, in the Survey of Consumer Finances.[5] Researchers interested in these questions for the U.S. have more frequently turned to panel data from the Health and Retirement Study (HRS), the Asset and Health Dynamics of the Oldest Old survey (AHEAD), the Panel Study of Income Dynamics (PSID), or the Medical Expenditure Panel Survey (MEPS). These surveys have at least two important advantages relative to the SCF. Perhaps most importantly, as noted by Hurd and Kapteyn (2001), Smith (1999, 2004), and others, these longitudinal data sources provide critical leverage in potentially identifying causal links between wealth and health by allowing researchers to isolate innovations to health or wealth. Second, these surveys include more detailed information on specific health conditions, health expenditures (as opposed to outstanding medical debt), and health insurance than is available in the SCF. In examining the

[4] Specifically, the SCF asks "Do you have any other loans?," and, at the interviewer's discretion, this question is followed up with "These may be loans for household appliances, furniture, hobby, or recreational equipment, medical bills, loans from friends or relatives, loans for a business or investment, or other loans." The latter portion is optional but reportedly is generally read by interviewers.

[5] Starr-McCluer (1996), Wenzlow *et al* (2004), Lyons and Yilmazer (2005), and Kennickell (forthcoming) each consider questions in this vein using the SCF; relevant results from each of these are discussed throughout the remainder of the paper.

relationship between wealth and health, Smith (1999, 2004) and Levy (2002) take advantage of both of these strengths by focusing on the effect of a new diagnosis of a chronic health condition on households' finances; to the extent its realization or timing is not anticipated, the new diagnosis may represent an exogenous "shock" to health.[6]

On the other hand, the detailed information in the SCF on the value of individual assets and debts within narrow categories yields a more complete picture of households' financial position and the relative importance of medical debt. The AHEAD, HRS, MEPS, and PSID each collect information on about a dozen or fewer categories of assets, and for many non-financial assets only the net value is reported.[7] Juster *et al* (1999) conclude that, by and large, this modest set of questions provides reasonably accurate measures of net worth for all but the wealthiest households. Of course, the less-extensive wealth modules can preclude analysis of narrower questions; for example, in this study I use the information on the loan purpose and lender in the SCF to identify medical debt and the sources of these loans. In contrast, medical debt in these other surveys is combined with a variety of other types of debts that are captured by a single question regarding debts not specifically covered elsewhere in the interview questionnaire.

The SCF also includes a number of measures of financial vulnerability as well as indicators of the role that medical expenses and health concerns play in households' finances and financial decision-making. These indicators include households' reasons for saving, major

[6] In this spirit, Lyons and Yilmazer (2005) use the retrospective SCF question about income last year compared to a "normal" year to construct a measure of "income shocks". This variable is key to identification of their simultaneous probits of health status and indicators of financial strain since it (as well as some other variables) is excluded from one of the equations.

[7] For example, the 2003 PSID Supplemental Wealth Files asked the value of: owner-occupied real estate; first and second mortgages and other home-secured debt; non-owner occupied real estate (net value); business or farm equity, (net value); vehicles (net value); stock in publicly held corporations, mutual funds, and investment trusts; transaction accounts (e.g., checking, savings, CDs); other assets (e.g., bond funds, cash value of life insurance); equity in IRAs; and debt other than mortgages or vehicle loans (e.g., credit cards, student loans, medical or legal bills) (See http://simba.isr.umich.edu/Zips/ZipMain.aspx, http://psidonline.isr.umich.edu/data/Documentation/wlth2003.html). MEPS includes the values of assets in similar categories and, for non-financial assets, collects both the market value of the asset and debt owed (Bernard *et al* (2007)). Asset modules in the HRS and the AHEAD survey are also similar to those in the PSID (See http://hrsonline.isr.umich.edu/concord/index.html and Smith (1995)).

foreseeable expenses, and sources of income fluctuations. Further, in contrast to the HRS and AHEAD, which capture information only on older households, the SCF is representative of all U.S. households and therefore allows analysis of both differences by age and changes over time. Because the SCF is a cross-section, researchers cannot use identification strategies such as first-differencing to estimate the causal effect of health on wealth, for example. However, it is worth noting that panel data approaches may come at a cost, since first-differencing and similar strategies can exacerbate the role of measurement error, as underscored by Juster *et al* (1999), resulting in less precise estimates and potentially misleading conclusions.

Results

The health-SES gradient in the SCF

The well established inverse relationship between health and socioeconomic status is apparent for several SES measures in the Survey of Consumer Finances (Table 1). The first row and column of the table indicate that for 30 percent of households in the SCF samples pooled from 1989 through 2004, either the head or spouse/partner, if applicable, assessed his or her health as fair or poor. This percentage falls monotonically with income, wealth, and education, as shown in the next three panels of the table.[8] For example, 50 percent of households in the bottom income quintile have a head or spouse/partner that reported being in either fair or poor health, compared to roughly 15 percent of households in the top income quintile.

The relatively high proportion of households with low income that report fair or poor health partially reflects declines in health associated with age, as illustrated in the bottom portion of the table, since retired households tend to have lower incomes. However, excluding households with a head aged 65 or older does not affect the qualitative findings; even over this

[8] Tests of the statistical significance of this and other results will be available in a forthcoming draft.

sample, the share of households reporting fair or poor health declines steadily with income, net worth, and education (not shown). The findings are in line with those of Wenzlow *et al* (2004) and Kennickell (forthcoming). Both of these studies use the SCF to examine the relationship between household characteristics and self-reported health status in a multivariate framework and conclude that wealth and income are positively and statistically significantly correlated with self-reported health after controlling for other factors such as age, education, and marital status.

Differences in health insurance coverage across income, net worth, and education categories mirror the differences in self-reported health status. The middle column of Table 1 shows the share of households within each of these groups for which some but not all family members have coverage, and the third column presents the share of households for which nobody in the household is covered. Households with net worth in the bottom quartile, for example, are about seven times more likely than those in top net worth decile to have at least one member who is uninsured and ten times more likely to have no coverage for any family member.[9] The share of households that do not have health insurance for some or all family members declines with age. The high rates of insurance coverage among the oldest group likely reflect in large part the near-universal Medicare coverage of individuals who are 65 or older.[10]

Trends in the health-SES gradient and in the role of health issues in household finances

The first three rows of Table 2 consider the same indicators—self-reported health and lack of insurance coverage for some or all family members—across survey years. These results

[9] These relationships between health insurance coverage and socioeconomic indicators again hold when excluding households with a head who is 65 years old or older.

[10] The fact that the share of households in the oldest age group without any insurance is not zero likely reflects both the fact that a small fraction of older individuals is not eligible for Medicare and potential respondent error (e.g., confusion regarding eligibility versus enrollment) that could not be resolved in review and editing of these data.

offer little evidence of a clear time trend in these measures.[11] In contrast, the third panel of the table suggests the reasons that household members are not covered by insurance may have shifted over time. The share of such households that reported the cost of obtaining insurance was the primary impediment to obtaining health insurance coverage rose from 72 percent in 1989 to 80 percent in 2004, after hovering around 73 percent in the earlier years. Conversely, the fractions reporting that they did not have insurance due to age or health conditions or that they were uninsured by choice both appear to have fallen somewhat on net between the 1989 and 2004 surveys.

The next three sets of rows in Table 2 consider the frequency with which households cite medical expenses as a reason for saving, an anticipated major expense, or the source of a recent drop in income. At least when looking over all households, medical expenses are rarely reported as the primary motive for saving. In the pooled sample, only 3 percent of households cite the need to save in case of illness or for medical/dental expenses as the most important reason for saving; another 3 percent mention these as an additional reason for saving, after the primary motive. By comparison, roughly a quarter of households in the 1989–2004 surveys report that their primary reason for savings is for retirement, and about 10 percent cite education expenses as the most important reason for saving (not shown). Just over 20 percent of households reported that the most important reason for saving was for emergencies, "rainy days," or other similar unexpected needs, a broad category which of course could include medical contingencies. The fraction of households that specifically cite medical expenses as the primary reason for

[11] Chernew, Cutler and Seliger Keenan (2005) document the rise in the share of uninsured non-elderly individuals in the U.S. over the 1990s as measured by the Current Population Survey. They attribute most of this rise to increases in premiums, an effect that was only partially offset by expansion of Medicaid over this period. In most instances it is possible in the SCF to identify which individual household members are not covered by insurance, and one can distinguish government and private coverage. In a future draft, I intend to examine whether the roughly steady overall percentages of households with partial or no insurance coverage between 1989 and 2004 mask variation in individual coverage and in coverage by government versus private insurance.

saving is similar to the shares citing saving for family-related reasons (4 percent) or for purchase of a home (5 percent).

A comparison across years suggests that the prevalence of medical expenses as a reason for saving may have fallen slightly, with most of this apparent drop occurring between the 1989 and 1995 surveys. The estimated share of households that report health care expenses as a major foreseeable expense has likewise declined over time. The final rows of the table indicate that a small fraction of households—2 percent or less in any given year—report that their income in the prior year was unusually low compared to a "normal" year due to illness or disability. Looking only over households that reported that their prior year's income was comparatively low, nearly half reported the income drop was due to lower labor earnings, e.g., having worked less, loss of a job, or lower salary (not shown); illness or disability, cited by 9 percent of households with lower-than-normal income, is among the most common of the remaining reasons.

Differences in household finances by health insurance status and self-reported health

Table 3 examines how household balance sheets and debt burdens vary with health insurance coverage and health status.[12] Consistent with the results for net worth groups shown in Table 1, median net worth is much higher among households in which all family members have insurance than among households in which some or all members lack coverage. Similarly, households in which both the head and the spouse/partner (if applicable) report being in excellent or good health have a median net worth over twice the median for households where one or both reports being in relatively poorer health. Families with insurance for all members and those reporting better health are more likely to have assets, and the median value conditional on having assets is also higher for these families.

[12] To avoid potential confounding results due to life-cycle effects and near-universal Medicare coverage, this and subsequent tables exclude households in which either the head or spouse is aged 65 or older.

Both the fraction of households with debt and the median debt (for those with any debt) show a similar pattern to that for assets: better reported health and more complete insurance coverage are associated with higher rates of debt ownership and with higher median levels of debt. However, this pattern does not hold in the case of medical debt specifically. Instead, the incidence of outstanding medical debt is lower for households in which all family members are insured (4 percent) compared with those in the uninsured categories (6–7 percent), for example. In addition, the median amount of medical debt for families that have any is more similar across the groups. The incidence of medical debt is likewise higher among families in the "fair/poor" health status category than for those with better self-assessed health.

The remaining rows of the table indicate that households lacking health insurance coverage of all family members and those with worse health status may be more financially vulnerable. For example, over 20 percent of households without complete insurance coverage or reporting fair or poor health spent more than their income in the prior year, compared with 14 percent of other households. Similar disparities by insurance status and self-reported health are evident in the shares that have been turned down for credit (including having received less credit than they had applied for) at some time in the past five years and in the percentage of households with financial assets less than the reported desired level of buffer savings, a potential indicator of savings adequacy.[13] In contrast, there is little difference in the shares of households that had filed for bankruptcy in the last five years, a conclusion that holds for shorter time horizons as well (not shown).

Finally, looking over families with debt, those reporting worse health or lacking health insurance for at least one household member are roughly twice as likely to have missed a loan

[13] The desired level of buffer savings level is measured by the SCF question "About how much do you think you (and your family) need to have in savings for emergencies and other unexpected things that may come up?".

payment by 60 days or more at some time in the past year than other households. The share of households with regular debt payments exceeding 40 percent of their income, a common measure of high household debt burden, also declines with better self-reported health and more complete health insurance coverage.

Importance of medical debt on the household balance sheet

Table 4 examines in greater depth the relative importance of medical debt in the context of households' finances. The table indicates that, for households as a whole, medical debt is generally a small component of the balance sheet, but its importance varies across groups. As shown in the first row, just over 4 percent of families in the pooled 1989–2004 data have any outstanding medical debt, and the median and 75th percentile amounts of medical debt for these households are $1,200 and $3,300, respectively. The next two sets of columns measure medical debt balances and payments relative to other balance sheet components to provide an indication of the proportion of families for whom medical debt may represent a significant financial burden. Among households with medical debt, loans for medical expenses account for at least half of all debt for 23 percent of families and for at least half of non-mortgage debt for 32 percent of families. The fraction of such families for whom outstanding medical debt totals at least 50 percent of assets is 14 percent. Payments on medical debt account for at least half of debt payments for 18 percent of families that have medical debt, and for 5 percent of such families, payments on medical loans total 20 percent or more of total household income.[14] Finally, the right-most columns show that, aggregating across all households, medical debt is estimated to

[14] The smaller proportion of families for whom medical debt payments represent at least half of debt payments compared with the proportion with outstanding medical debt totaling at least half of all debt may in part reflect the fact that medical loans are more likely than other loans in the same debt categories in the SCF (lines of credit, second mortgages, home equity loans, and "other loans") to be reported as having no regular or "typical" payment.

represent only a fraction of a percent of all outstanding debt and about 1.5 percent of non-mortgage debt.

The significance of medical debt as a component of the household balance sheet differs by household demographics, health status, and insurance coverage, however. The incidence of medical debt, for example, is greater among families with a head or spouse/partner in fair or poor health and among families without complete health insurance coverage compared with other families. Differences in the median amount of medical debt are less pronounced, particularly when comparing households by health insurance status, but the 75th percentile value rises steadily across these groups. Similarly, the proportions of households for whom medical debt or medical debt payments are large relative to other balance sheet components are greater among households with poorer self-reported health or incomplete insurance coverage.

There is even greater variation by income and net worth in the shares of families with large amounts of medical debt relative to other types of debt, assets, or income. For instance, among families with any medical debt, medical debt accounts for at least 50 percent of all debt for nearly one third of families in the bottom net worth quartile, whereas the corresponding fraction among households in the top quartile is less than one tenth. The gradient is steeper across income ranges. Interestingly, the shares of households for whom medical debt accounts for 50 percent or more of all debt or for whom medical debt payments are more than 50 percent of debt payments ticks up in the top net worth and income groups. Households in the upper portions of the net worth and income distributions are less likely than other families to have medical debt, but the conditional medians and 75th percentiles are notably higher for these families than for other households. The estimated proportions of families with medical debt equal to at least half of assets falls to zero for households with net worth above the 25th

percentile, and the share for whom medical debt payments are 20 percent or more of income is essentially zero for families with income above the 60th percentile.

The share of families with medical debt generally declines with age, whereas the conditional median and 75th percentile values tend to rise for the older age groups. The percentages of families with high levels of medical debt or medical debt payments when measured as shares of other balance sheet components typically fall slightly with age before rising to a peak among households in the oldest age group. The differences by age, however, tend to be smaller than those across other categories. As shown in the final rows of the table, the estimates of the incidence, amount, and aggregate shares of medical debt do not suggest a clear trend between 1989 and 2004 in the importance of medical debt on the household balance sheet.

The findings that households without full insurance coverage are more likely to have medical debt than fully insured families and that conditional medians of medical debt vary little by insurance status generally hold within subgroups defined by demographic characteristics or self-reported health (Table 5). Comparing the first two columns, uninsured households are more likely to have outstanding debt for medical expenditures than insured households within each of the demographic categories.[15] Differences by insurance status in the median amount of medical debt, conditional on having any, are often small. More often than not, the conditional median for uninsured households is lower than that for insured households, and the instances where the gap reverses may entirely reflect sampling variability of the estimates. Nonetheless, it is notable that these exceptions to the general pattern occur for households that may be more vulnerable to health shocks, specifically families in the lowest income and net worth groups and those in which either the head or spouse/partner reports being in fair or poor health.

[15] To ensure sufficient sample sizes within cells, the table combines net worth categories above the median and income categories above the 60th percentile. Similarly, households with some uninsured family members are combined with those for which all family members are uninsured.

The conclusions that uninsured households with medical debt are more likely than households with full insurance to have high ratios of medical debt to non-mortgage debt and high ratios of medical debt payments to all debt payments are more sensitive to conditioning on demographic characteristics. Moreover, these conclusions generally do not hold across survey years. For example, within subgroups defined by age, net worth, or self-reported health status, medical debt is more likely to be half or more of all non-mortgage debt for uninsured households than for insured households, in line with the overall differences shown in Table 4. However, for households in the second and third income quintiles that have medical debt, the share of uninsured families with high levels of medical debt by this measure is slightly lower than the share among fully insured families. In addition, the gap in this measure for the pooled 1989–2004 sample appears to be driven by differences in the 1992 and 1995 surveys that are not apparent in other years. Similarly, after conditioning on the subgroups considered in the table, the shares of families with medical debt for whom the majority of debt payments are attributable to medical loans, shown in the final columns, do not show a consistent pattern by insurance coverage.

Conclusion

This paper highlights relationships between self-reported health, health insurance, medical debt, and household finances using data from the U.S. Survey of Consumer Finances. In addition to illustrating the health-SES gradient found in numerous studies, the paper draws on several components of the SCF to provide a more-detailed picture of the role that health and medical concerns play in household finances. First, the paper examines how measures of financial vulnerability vary with self-reported health status and with health insurance coverage. Second, the paper extends prior studies by utilizing the detailed information on debts in the SCF

to examine how the amount and shares of debt and debt payments attributable to medical expenditures vary across households.

I find that, on the whole, medical debt is generally a small component of household liabilities; less than 5 percent of all households reporting outstanding medical debt at the time of the interview. Analysis of families' reported reasons for savings, for instance, similarly suggest that, although medical expenses are among households' most important savings motives, they appear to be less prominent reasons than retirement or educational expenditures, at least when looking across all households. Importantly, however, medical debt is a substantial portion of debt for some select subgroups; for example, medical debt totals at least half of all debt for one-third or more of low-income and low-wealth households that have medical debt. Medical debt generally also plays a larger role in the balance sheets of uninsured households and of households in which either the head or spouse reports being in only fair or poor health, though some of these difference may of course reflect correlations with other household characteristics.

These descriptive results are intended to form the basis of a more in-depth analysis of the role that medical expenses and health concerns play in households' finances and financial decision-making. Like empirical associations between health and SES indicators, the correlations between health and health insurance, on the one hand, and medical debt and financial vulnerability, on the other, could be driven by a variety of mechanisms. For example, a pre-existing medical condition may both prevent an individual from obtaining insurance and lead to high medical bills. Alternately, households who choose to self-insure may have comparatively high levels of medical debt because all medical costs are paid out of pocket, not necessarily because they face particularly frequent or expensive medical shocks. These households may also choose to finance their medical expenses rather than to pay for them out of

savings or income; their medical debt may therefore indicate a payment choice rather than financial or health vulnerability. This preliminary analysis cannot disentangle the variety of potential causal relationships.

Finally, the results suggest that incorporating indicators of households' vulnerability to medical expenditure shocks would likely lead to estimates of greater inequality in household well-being than would be obtained from inequality measures based only on income or wealth. In particular, differences across groups in self-reported health, insurance coverage, and the magnitude of medical debt suggest these factors tend to reinforce disparities in income and wealth. Consequently, lower-income and lower-wealth families may be more likely to experience a negative health shock and may face greater financial consequences if such a shock occurs. A number of approaches to defining multi-dimensional measures of inequality have been developed in recent years, and identifying the merits and drawbacks of each and refinement of these techniques is an area of ongoing research.[16] Drawing on this literature to quantify the extent to which estimates of inequality would change when considering a broader measure of well-being that encompasses health-related indicators would be an important extension of the results presented here.

[16] See, for example, Nilsson (2007) and Justino (2005) for empirical applications and comparisons of techniques for analyzing inequality in multiple dimensions.

References

Adams, Peter, Michael D. Hurd, Daniel McFadden, Angela Merrill and Tiago Ribeiro. 2003. "Healthy, Wealthy, and Wise? Tests for Direct Causal Paths between Health and Socioeconomic Status." *Journal of Econometrics* 112: 3–56.

Bernard, Didem, Jessica Banthin, and William Encinosa. 2007. "Wealth, Assets, and the Affordability of Health Insurance." Working paper, Economic Research Initiative on the Uninsured.

Bucks, Brian K., Arthur B. Kennickell and Kevin B. Moore. 2006 "Recent Changes in Family Finances: Evidence from the 2001 and 2004 Survey of Consumer Finances." *Federal Reserve Bulletin*: A1–A38.

Chernew, Michael, David Cutler and Patricia Seliger Keenan. 2005. "Increasing Health Insurance Costs and the Decline in Insurance Coverage." ERIU Working Paper 8.

Deaton, Angus. 2002. "Policy Implications of the Gradient of Health and Wealth." *Health Affairs* 21(2): 13–30.

Hurd, Michael and Arie Kapteyn. 2001. "Health, Wealth, and the Role of Institutions." *Journal of Human Resources* 38(2): 386–415.

Juster, F. Thomas, James P. Smith and Frank Stafford. 1999. "The Measurement and Structure of Household Wealth." *Labour Economics* 6(2): 253–275.

Justino, Patricia. 2005. "Empirical Applications of Multidimensional Inequality Analysis." PRUS Working Paper 23.

Kennickell, Arthur B. 2001. "Modeling Wealth with Multiple Observations of Income: Redesign of the Sample for the 2001 Survey of Consumer Finances." Working paper, Board of Governors of the Federal Reserve System.

Kennickell, Arthur B. 2007. "The Role of Oversampling of the Wealthy in the Survey of Consumer Finances." Working paper, Board of Governors of the Federal Reserve System.

Kennickell, Arthur B. (Forthcoming). "What Is the Difference? Evidence on the Distribution of Wealth, Health, Life Expectancy and Health Insurance Coverage." *Journal of Statistics in Medicine*.

Kennickell, Arthur B. and R. Louise Woodburn. 1999. "Consistent Weight Design for the 1989, 1992, and 1995 SCFs, and the Distribution of Wealth." *Review of Income and Wealth* 45(2): 193–215.

Levy, Helen. 2002. "The Economic Consequences of Being Uninsured." ERIU Working Paper 12.

Lyons, Angela C. and Tansel Yilmazer. "Health and Financial Strain: Evidence from the Survey of Consumer Finances." *Southern Economic Journal* 7(14): 873–890.

Nilsson, Therese. 2007. "Measuring Changes in Multidimensional Inequality—An Empirical Application" Working Paper, Lund University.

Smith, James P. 1995 "Racial and Ethnic Differences in Wealth in the Health and Retirement Study" *Journal of Human Resources* 30 (Supplement): S158–S183.

Smith, James P. 1999. "Healthy Bodies and Thick Wallets." *Journal of Economic Perspectives* 13(2): 145–166.

Smith, James P. 2004. "Unraveling the SES: Health Connection." *Population and Development Review* 30 (Supplement): 108–132.

Starr-McCluer, Martha. 1996. "Health Insurance and Precautionary Savings" *American Economic Review*: 86(1): 285–295.

Wenzlow, Audra T., John Mullahy, Stephanie A. Robert and Barbara L. Wolfe. 2004. "An Empirical Investigation of the Relationship between Wealth and Health Using the Survey of Consumer Finances." Working paper, Russell Sage Foundation.

Table 1: Self-Reported Health and Health Insurance Status by Selected Household Characteristics

Percent

Household Characteristic	Head or Spouse/Partner in Fair/Poor Health	Health Insurance Coverage	
		Partial	No Coverage
All Households	30	19	9
Income Percentile			
Less than 20	50	32	18
20–39.9	37	28	15
40–59.9	27	19	9
60–79.9	22	11	4
80–89.9	17	6	2
90–100	12	4	1
Net Worth Percentile			
Less than 25	38	36	21
25–49.9	32	22	10
50–74.9	28	12	5
75–89.9	24	8	2
90–100	19	5	2
Education of Head			
No high school diploma	57	31	15
High school diploma	33	22	11
Some college	25	19	9
College degree	16	10	5
Age of Head			
Less than 35	18	29	16
35–44	21	20	11
45–54	27	20	9
55–64	39	18	8
65 or older	51	7	2

Notes: Pooled data from 1989–2004 Surveys of Consumer Finances. "Partial" health insurance coverage refers to households in which at least one but not all household members are uninsured. "No Coverage" refers to households in which no household member has health insurance.

Table 2: Trends in Health, Health Insurance, and Medical-Related Financial Indicators: 1989–2004 Surveys of Consumer Finances

Percent

Percent of Households With:	1989-2004	Year 1989	1992	1995	1998	2001	2004
Head or Spouse/Partner in Fair/Poor Health	30	30	29	30	30	31	30
Health Insurance							
Someone uninsured	19	19	20	18	19	17	21
All uninsured	9	9	9	9	10	9	10
Reason no health insurance[1]							
Too expensive	75	72	74	73	74	75	80
Can't get: ineligible	11	8	10	13	12	13	10
Can't get: Age or health	3	5	5	3	2	2	2
Don't want or need	7	10	8	6	8	4	7
Illness or medical/dental expenses as savings reason							
Primary reason for saving	3	5	4	3	3	3	2
Any reason for saving	6	9	7	6	5	6	5
Expect major health care/medical expenses in next 5–10 years?[2]							
Yes	17	21	20	18	13	14	15
Income unusually low last year due to illness or disability[3]							
All households	1	—	—	2	2	1	1
Households with unusually low income last year	9	—	—	10	11	7	7

Notes: [1] "Can't get: Age or health" includes those who said they could not get insurance due to poor health, age, illness, or a pre-existing condition. "Can't get: ineligible" includes families without insurance due to job loss, lack of coverage on the job, loss of parental coverage, or loss of public assistance. "Don't want or need" consists of those reporting they did not believe in health insurance or did not need it because there was not much sickness in the family as well as those reporting they self-insured or could manage their health without insurance. Columns do not sum to 100 due to omission of other categories.

[2] Respondents could provide up to 6 anticipated financial obligations in the 1995–2004 surveys, up to 5 in 1992 survey, and up to 3 in 1989 survey.

[3] Question was not asked in 1989 and 1992 SCFs.

Table 3: Household Balance Sheet Components and Selected Financial Characteristics by Health Insurance Status and Self-Reported Health

	Health Insurance Status			Self-Reported Health	
	All Covered	Some Uninsured	All Uninsured	Excellent/Good	Fair/Poor
Median net worth	86.4	19.8	7.9	76.4	30.2
Have any assets	97%	95%	90%	97%	92%
Median assets	163.9	54.4	21.0	151.0	71.7
Have any debt	86%	81%	68%	85%	76%
Median debt	49.9	19.7	11.4	48.0	20.6
Have medical debt	4%	7%	6%	3%	7%
Median medical debt	1.3	1.1	1.2	1.1	1.4
Spending exceeded income last year	14%	22%	22%	14%	21%
Filed for bankruptcy in past five years[1]	5%	4%	5%	5%	6%
Turned down for credit in past five years	23%	36%	31%	25%	28%
Financial assets < desired buffer savings[1]	25%	53%	65%	27%	47%
Debtors					
Payment 60+ days past due in last year	6%	16%	16%	6%	14%
Debt payments > 40 percent of income	10%	17%	18%	11%	14%

Notes: Medians are thousands of 2004 dollars. Median assets, debt and medical debt conditional on having any; late payments and payment-to-income ratio > 40 percent condition on having debt. Pooled data from 1989–2004 Surveys of Consumer Finances for households with both head and spouse/partner (if applicable) under 65.

[1] Bankruptcy question first asked in 1998 SCF, and desired buffer savings level first asked in 1995 SCF.

Table 4: Relative Magnitude of Medical Debt and Medical Debt Payments by Selected Household Characteristics

Percent unless noted

	Have Medical Debt	Medical Debt (Thous. 2004 $)[1]		Medical Debt ≥ 50% of[1]			Medical Debt Payments[1]		Medical Debt Share of	
		Median	75th Percentile	All Debt	Non-Mortgage Debt	Assets	≥ 50% of Debt Payments	≥ 20% of Income	All Debt	Non-Mortgage Debt
All Households	4.4	1.2	3.3	23	32	14	18	5	0.3	1.5
Health Status										
Excellent/Good	3.5	1.1	2.8	17	27	11	15	4	0.2	0.8
Fair/Poor	7.2	1.4	4.3	31	38	18	22	7	1.4	4.6
Health Insurance										
All insured	3.7	1.3	3.0	19	29	10	16	4	0.2	1.1
Some insured	7.3	1.1	3.5	27	33	16	20	8	1.1	3.5
None insured	6.3	1.2	3.9	32	41	24	21	9	1.5	4.4
Net Worth Percentile										
Less than 25	6.9	1.2	3.6	32	35	31	22	7	2.6	4.0
25–49.9	5.0	1.3	2.6	18	32	0	17	4	0.3	1.2
50–74.9	3.7	1.2	3.5	14	25	0	12	5	0.2	1.0
75–89.9	1.5	2.5	7.2	3	22	0	5	2	0.1	0.7
90–100	0.7	2.6	4.7	8	29	0	8	0	0.0	0.2
Income Percentile										
Less than 20	5.8	1.0	4.4	43	46	36	30	14	2.3	5.0
20–39.9	6.2	1.1	2.9	25	37	13	20	6	1.3	3.8
40–59.9	5.7	1.4	3.5	19	29	7	13	2	0.8	2.4
60–79.9	3.5	1.2	2.6	8	15	5	10	0	0.2	1.0
80–89.9	2.4	1.8	5.3	8	26	0	9	0	0.1	0.7
90–100	1.0	1.3	7.2	10	14	0	12	0	0.0	0.2
Age of Head										
Less than 35	5.7	0.9	2.6	23	31	14	17	4	0.5	1.9
35–44	4.2	1.3	3.3	21	30	13	16	6	0.2	1.2
45–54	3.4	1.6	4.6	22	34	10	15	4	0.3	1.3
55–64	3.5	1.2	5.1	28	34	17	26	11	0.4	1.6
Year										
1989	5.4	1.5	3.6	23	34	12	22	10	0.6	1.7
1992	7.7	1.0	2.6	26	33	15	16	5	0.5	2.0
1995	4.4	1.1	3.8	14	22	6	12	2	0.3	1.4
1998	3.1	1.2	3.0	21	37	10	18	2	0.3	1.0
2001	3.6	1.5	2.8	29	37	17	18	7	0.3	1.4
2004	2.8	1.5	4.3	23	27	22	19	5	0.3	1.6

Note: Pooled data from 1989–2004 Surveys of Consumer Finances for households with both head and spouse/partner (if applicable) under 65.

[1] Debt percentiles and percentages of households conditional on having any medical debt.

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Table 5: Relative Magnitude of Medical Debt among Household Liabilities by Selected Household Characteristics and Health Insurance Status

	Percent with Medical Debt		Median Medical Debt (Thous. of 2004 Dollars)		Medical Debt ≥ 50% of Non-Mortgage Debt		Medical Debt Pmts ≥ 50% of Debt Payments	
	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured
Health Status								
Excellent/Good	3.1	4.9	1.2	0.9	25	33	13	19
Fair/Poor	5.8	10.3	1.3	1.6	37	40	22	21
Net Worth Percentile								
Less than 25	6.5	7.7	1.1	1.3	31	41	20	25
25–49.9	4.6	6.3	1.3	1.0	31	35	18	16
50–100	2.1	5.4	1.3	1.3	24	27	10	13
Income Percentile								
Less than 20	5.6	6.0	0.7	1.3	39	54	30	30
20–39.9	5.3	7.6	1.3	1.0	37	36	21	19
40–59.9	5.0	8.0	1.4	1.4	30	26	15	9
60–100	2.3	5.4	1.4	1.1	17	22	7	24
Age of Head								
Less than 35	5.1	7.2	1.0	0.9	29	34	17	17
35–44	3.6	6.6	1.3	1.1	28	35	12	25
45–54	2.8	5.9	1.7	1.5	31	40	15	14
55–64	2.7	7.1	1.5	1.1	28	46	24	29
Year								
1989	4.3	9.0	1.8	1.2	34	34	21	23
1992	6.1	12.8	0.9	1.3	25	45	13	21
1995	4.1	5.5	1.1	1.1	17	37	11	17
1998	2.8	4.2	1.4	0.6	39	31	18	16
2001	2.8	6.4	1.2	1.7	37	38	20	16
2004	2.5	3.7	1.5	1.0	29	22	16	27

Note: "Insured" includes households in which all members have health insurance coverage. "Uninsured" includes households in which at least one member is uninsured. Median debt and percentages of households conditional on having any medical debt. Pooled data from 1989–2004 Surveys of Consumer Finances for households with both head and spouse/partner (if applicable) under 65.

The Prepared Statement of Kerry Burns, Coventry, Rhodes Island

Chairman Whitehouse, Ranking Member Sessions, Members of the Committee, thank you for the opportunity to participate in today's hearing. My name is Kerry Burns, and I am from Coventry, RI. I am here to tell the story of my family's medical debt. My story starts in 2004 with the birth of my son, Finnegan. A day after Finnegan's birth, he was diagnosed with Cystic Fibrosis, something that shocked and devastated me and my husband, Patrick. Finnegan was a fighter from the start—after some initial difficulties, he thrived in all areas. He was a bright, funny, caring and loving little boy, who was the light of our lives. Finnegan was hospitalized in intensive care for thirteen months before he passed away this past March at four and a half years old.

In February 2008, Finnegan became sick with what we thought was just a common cold. After several days of vomiting and simply not feeling well, Finn's doctors suggested we bring him to the hospital to see if he was dehydrated. When we brought Finn to the emergency room, the doctors ascertained that he had a major bowel obstruction, which required surgery. The night of the surgery, Finn went into cardiac arrest and we were told by the surgeon that Finn would likely not survive the necessary emergency surgery.

Finn did survive that surgery. He had six surgeries in his first nine days in the hospital, and survived countless others. He was intubated for almost two months and then received a tracheotomy. Finn was in very rough shape, but slowly, amazingly, his condition began to improve. He showed a fierce spirit and will to live. Finnegan spent a total of eight months at Hasbro Hospital in Providence. We were then sent to Yale University for transplant evaluation. It was determined that Finnegan would require a multi-organ transplant, and we were transferred to Georgetown University Hospital here in Washington.

My husband and I stayed right by our son's side during every step of his fight. To do this, we both had to take leave from our jobs. We could not, however, have anticipated how long Finn's treatment would last, or the ultimate financial ramifications of our decision to be with him.

During this period, we had only temporary disability income and unemployment benefits, which were far less than we had earned before. We struggled to pay our monthly bills including our mortgage. As our money dwindled and the bills began to pile up, we did everything we could to keep our heads above water, including cashing in our retirement funds and selling belongings for extra money. Once we were sent to Georgetown for care, we sold our second car. Family and friends were gracious and generous enough to donate money to help us.

Eventually, the bills piled up beyond our ability to pay them. We were forced to default and, despite our circumstances, creditors were unwilling and/or unable to work with us. They wanted money and we simply had none to give them. The collection calls were unrelenting—upwards of 30 calls to each our cell phones each day—all while we were in an intensive care unit willing our son back to health.

As Finn's hospitalization stretched from weeks to months, we had to make difficult decisions about which bills to pay. The top priority was retaining ownership of our home and I am proud to say that we were able to make our mortgage payments through ten months of Finn's hospitalization. Unfortunately, starting this past January, we were no longer able to make our mortgage payments.

The emotional hardship my husband and I endured over the course of our son's hospitalization pales in comparison to what we have felt since his loss—losing a child is the greatest injury for a parent and something we would not wish on anyone. As if this loss were not enough to handle, and rebuilding our lives without our son was not hard enough, we have been faced with financial ruin.

When people hear about our story and our financial problems, it is often assumed that we did not have medical insurance to cover Finn's expenses. We did have insurance, and the vast majority of Finn's treatments—totaling nearly five million dollars—were covered. We were lucky enough that my husband's former-employer covered our insurance for several months. After that, we had to pay extensive COBRA fees to maintain our insurance until being approved for state sponsored health care.

Our return to RI from Washington was difficult for many reasons. First and foremost, we came "home" without the most important person in our lives. We had so little money left, that I was selling belongings on EBay to get gas and toll money for the ride home. Back in RI, we did not return to our house, as we were unsure of when the foreclosure process would actually "take" it—instead, we lived with friends in their apartment for two months. We had difficulty renting an apartment because our credit has been ruined. In order for both my husband and I to return to work, we need two cars. We only have one, and will be unable for some time into the future to obtain a second.

I had no prior knowledge about how one would file bankruptcy, and certainly never thought I would be in the position to have to do so. I have found that it is a demeaning and demoralizing process, one that my husband and I are in through no fault of our own. We simply made the right choice as parents, to be with our son in his greatest time of need. In order to file bankruptcy, we needed money for a $250 retainer and a $1300 filing fee. We had to borrow the money needed to "officially" go bankrupt.

As if this were not enough, a credit counseling class is required, both before and after the filing, with fees in addition to the other costs of filing. My husband and I sat down to take this class online, and were surprised by the tone of the questions—which seemed quite insulting, which included those about why we are going bankrupt and how we could have avoided the situation in which we currently find ourselves. In addition, the course required us to recalculate and resubmit the financial information already submitted to our lawyer.

I believe the Medical Bankruptcy Fairness Act, introduced by Chairman Whitehouse, would help families like mine recover from medically-based financial hardship. As I understand it, the bill would waive some of the procedural hurdles to bankruptcy relief including the humiliating credit counseling requirement. The bankruptcy system needs to be modified to take into account how people came to bankruptcy.

I have worked since the age of 14. I have a master's degree and have spent my professional social work career helping others. To not be able to help myself and my husband financially, after not being able to save my son, is embarrassing and shaming, and truly adds insult to injury. It is my hope that by sharing our story, changes can be made to the system to help others in similar situations in the future. Thank you.

Statement of

Elizabeth Edwards

Senior Fellow

Center for American Progress Action Fund

Before the

Committee on the Judiciary

Subcommittee on Administrative Oversight and the Courts

United States Senate

October 20, 2009

Chairman Whitehouse and Members of the Subcommittee, thank you for inviting me here today to discuss the causes and consequences of medical bankruptcy. We are in the middle of a great national debate on health care. For the first time in more than 15 years, we are truly trying to fix the broken health care system – and deal with the twin problems of the status quo, skyrocketing health care costs and the millions of Americans living without health coverage. As Congress and the Administration wrestle with the big picture and the very important details, it will be critically important to ensure that health reform guarantees that coverage and care will be affordable for Americans of all incomes.

I know that the Committee is concerned about the financial hardships that many Americans experience due to health care costs, particularly bankruptcy. As you know, medical expenses are a major factor in nearly two-thirds of bankruptcy filings.[1] People with poor or no health insurance coverage and a significant health problem are more likely to accrue considerable medical debt than people who have good coverage and good health – and thus are particularly vulnerable to bankruptcy. Yet when they reach bankruptcy court, the bankruptcy trustee has little ability and little incentive to address the underlying factors that have led to medical debt and medical bankruptcy, including insurance company denials and aggressive collection efforts by medical debt collectors. Medical debt is, of course, a symptom of larger problems in our health care system – and the solution to medical debt and medical bankruptcy is real health reform that results in affordable, reliable health coverage and affordable health care for all Americans.

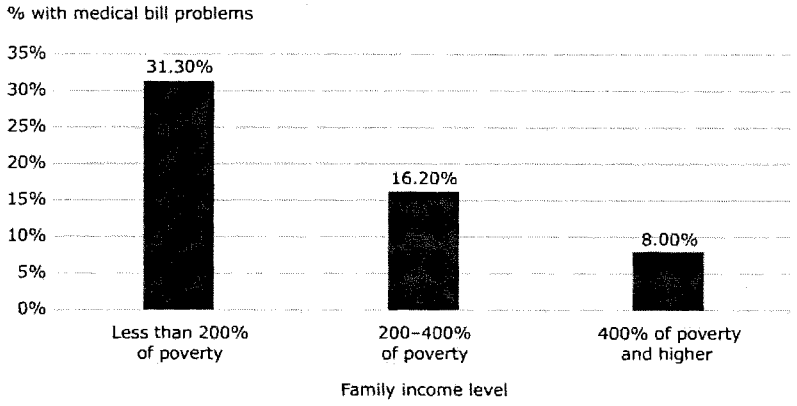
The problem of unaffordability is most apparent for the nearly 47 million Americans who lack health insurance. Roughly two thirds of Americans without health insurance have incomes below 200 percent of the federal poverty level—or approximately $44,000 for a family of four. Most people without health insurance are workers or live in families with a worker, but do not have health coverage through an employer.[2] With the annual average cost of employer-sponsored health insurance nearing $13,000 in 2008, health insurance is clearly unaffordable for families who must purchase it on their own.[3]

Sadly, even people who actually have health insurance increasingly face problems paying for health care. A growing number of Americans with health insurance face affordability problems for health insurance and for health care. For example, a recent analysis by the Commonwealth Fund identified 25 million adults with health coverage as underinsured – that is, they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or, for low-income adults (defined as 200 percent of the federal poverty level), at least 5 percent of family income; **or** if they faced deductibles of at least 5 percent of family income. This represents a 60 percent increase from the 15.6 million Americans who were underinsured in 2003.[4]

Another study, which explored families' actual problems paying medical bills, found that one if five Americans reported problems paying medical bills in 2007. This work from the Center for Studying Health System Change indicates that even moderate levels of out-of-pocket spending relative to family income – that is, spending that is well below the 5 or 10-percent of family income considered to be underinsured by the studies just cited – created medical bill

problems. For example, two-thirds of the individuals who reported trouble paying medical bills spent 5 percent or less of their family income on health care.[5] As author Peter Cunningham noted, many families have little wiggle room within their family budgets for large or unexpected out-of-pocket health care expenses. And even a relatively low level of health care spending compared to family income can create financial stress for low-income families. (See chart below.)

Burden of medical bills for families spending 2.5% or less of family income

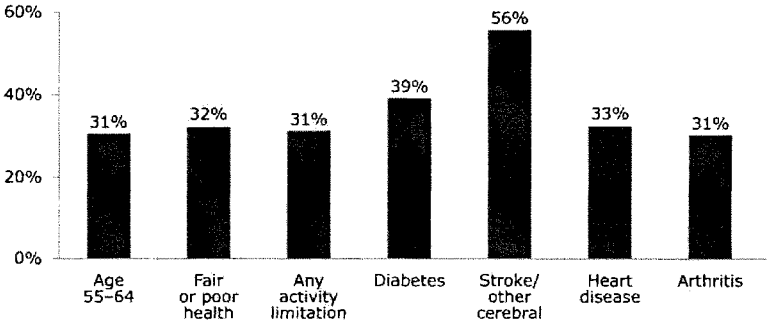


Source: P. Cunningham, C. Miller and A. Cassil, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change.

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income but also by health status. Health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care. In particular, individuals who are older, have an activity limitation, have a chronic condition such as diabetes, heart disease, or arthritis, or have

experienced stroke, are more likely to spend a high proportion of their income on health expenses. (See chart below.) If these individuals are not covered by an employer-sponsored health plan, or lose this coverage, their ability to purchase coverage in the non-group market is limited at best. Far from serving as a safety-net, the non-group market systematically denies coverage, limits benefits or charges excessive premiums to individuals with pre-existing conditions or whom they perceive as likely to need care. And if these individuals do have coverage through the non-group market, they are more likely to have their coverage unfairly rescinded by their insurance company or experience a rapid increase in premiums to maintain their coverage. Ironically, then, underinsurance or financial problems are most likely to arise for people who get sick—the very population that insurance is supposed to protect.

Groups at high risk of having high financial burden for health care, 2003



Note: High Financial Burden defined as families spending more than 10% of their after-tax income on health care, including premiums and out-of-pocket health costs.

Source: Kaiser Family Foundation, based on Banthin, JS and DM Bernard. "Changes in Financial Burdens for Health Care," JAMA 296(22), December 2006.

The Consequences of Affordability Problems

We know that unaffordable health insurance makes health care itself unaffordable and unavailable. As the Institute of Medicine recently noted, there is a chasm between the health care needs of people without health insurance and access to effective health care services. People without health insurance are more likely to delay care, to get less care, and to die when they get sick.[6]

People who are underinsured can experience very similar problems getting needed care. According to the Commonwealth Fund, underinsured individuals are two to three times as likely as insured individuals to forgo various needed medical services because of cost[7] Of sicker underinsured adults, a full two-thirds went without needed care due to cost, including half of individuals with a chronic condition forgoing necessary medications.[8] According to a recent Kaiser Family Foundation survey, concerns about affording needed medical care led insured individuals to cut back on care due to cost. Responses included postponing care (34%), skipping a recommended medical visit or treatment (30%), not filling prescriptions (27%), and skipping doses or cutting pills (21%).[9]

People who are under-insured not only face the medical problems of inadequate treatment; they also face financial problems from the treatment they actually get. Of sicker underinsured adults, three-fifths reported having been contacted by a collections agency. In a 2007 survey, respondents reported making difficult choices between using up a lifetime of savings, running up credit card debt, skipping the purchase of other necessities, or adding a mortgage against their home in order to pay medical bills.[10]

Home mortgage foreclosure, another personal financial catastrophe, is also related to health care expenses. Seven out of ten respondents in a recent survey of borrowers in foreclosure reported unmanageable medical bills as an underlying cause of their foreclosure, or had experienced other medical disruptions to their income, such as lost work due to illness or using home equity to pay medical bills.[11]

Finally, medical bankruptcy represents the far extreme of the financial problems individuals without health insurance or with inadequate insurance can face. Hard-to-manage health care spending may not appear as easily-identifiable medical debt, but may instead be hidden in second mortgages, large credit card debt or unsecured loans. Many medical debtors turn to borrowing to cover accrued medical expenses in order to continue treatment – and continuing treatment may be their highest priority. For example, a recent debtor in eastern North Carolina incurred $30,000 in uncovered medical expenses for a child who needed cardiac surgery. He borrowed $30,000 to pay for that first surgery because a necessary second surgery was withheld until the first bill had been paid. With $30,000 in unreimbursed medical expenses from the second surgery, as well as loans to cover the initial surgery, the father was forced into bankruptcy.

In some cases, bankruptcy may be driven not by underinsurance but by bad insurance company practices. Unfortunately, bankruptcy trustees have little opportunity or incentive to look into unwarranted denial of claims or unwarranted rescission of coverage – even though these practices may push individuals with health coverage into bankruptcy. And those who

suffer from a wrongful rescission or denial include not only the debtor, but also all the other creditors, whose debts are devalued by the bankruptcy filing.

Bankruptcy Reform and Medical Debt

One approach that would provide immediate relief to medical debtors would be to reform bankruptcy rules for individuals who are driven to bankruptcy by medical expenses or the secondary effects of medical expenses. Senator Whitehouse, for example, recently introduced the Medical Bankruptcy Fairness Act (S. 1624). This proposal would provide individuals with medically-related debts easier access to Chapter 7 to discharge their debts. It would also allow medical debtors to retain at least $250,000 in home value, and enable them to bypass burdensome and inappropriate credit counseling requirements. This approach would give medical debtors a less burdensome, less catastrophic bankruptcy option that recognizes the unique circumstances that have driven them to bankruptcy. Until our nation implements systemic health reform – and ensures that coverage and care are truly affordable – we must open new avenues for families struggling under crushing medical debts.

Ending Medical Bankruptcy: Health Reform and Affordability

Patients with cancer and other chronic conditions, low-income families and individuals who are currently uninsured all hope to gain greater financial stability and access to health care with health reform. Successful health reform must not just make health insurance affordable; affordable health insurance has to make health care affordable.

I am confident that Congress will conclude that the problems I have outlined in my testimony – families forced into bankruptcy, people with chronic conditions going without necessary care, low-income families experiencing the squeeze of unexpected medical bills – are merely a symptom of the larger problems in our health care system. Today we leave too many Americans without health insurance – and even more without adequate coverage. High deductibles and unrealistic copayment responsibilities leave people with chronic illness at perpetual risk of financial ruin. Health insurance companies are able to deny coverage to people with health problems, exclude pre-existing conditions from coverage when they offer it, and charge unmanageable premiums. They can even rescind coverage when their policyholders get sick, leaving people who had faithfully paid their premiums without the financial protection they thought they had paid for.

Congress can fix these problems. Health reforms that ensure that all Americans have health insurance coverage with adequate benefits and reasonable copayment responsibilities will provide real financial protection and real access to health care services. Health reforms that curb insurance companies' discriminatory practices will ensure that everyone can purchase and retain comprehensive coverage, including coverage for pre-existing conditions. And health reforms that require everyone to have coverage, while guaranteeing that individual and family premium contributions are affordable, will end the cost-shifting and uninsurance that are hallmarks of the current system.

A Chance Not to be Missed

Along with every other American, I am counting on the Congress and the President to enact reform that will provide answers to these questions—answers that will give all of us affordable coverage and affordable, quality health care. I can't help asking myself how things would be different if we had achieved health reform in 1993 or 1994. Would millions of people be going without needed treatment? Would families be facing medical bills they cannot pay? We've asked these questions for too many years and watched too many families suffer. It's time to stop asking questions and provide the answers Americans are looking for. We can and must seize this opportunity to effectively reform our health care system for the American people.

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[1] D. Himmelstein, D. Thorne, E. Warren, S. Woolhandler, "Medical Bankruptcy in the United Sttes, 2007: Results of a National Study," *The American Journal of Medicine,* August 2009 (Vol. 122, Issue 8, Pages 741-746), available at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

[2] Kaiser Family Foundation, *The Uninsured: A Primer*, October 2008, available at: http://www.kff.org/uninsured/upload/7451-04.pdf.

[3] Kaiser Family Foundation/Health Research and Education Trust, "Employer Health Benefits 2009 Annual Survey," available at: http://chbs.kff.org/pdf/2009/7936.pdf.

[4] C. Schoen, S. Collins, J. Kriss and M. Doty, "How Many are Underinsured? Trends Among U.S. adults, 2003 and 2007," *Health Affairs* 27 no. 4 (2008):w298-2309.

[5] P. Cunningham, C. Miller and A. Cassil, "Living on the Edge: Health Care Expenses Strain Family Budgets," *Research Brief,* Center for Studying Health System Change, No. 10, December 2008.

[6] Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care," *Report Brief,* February 2009, available at: http://www.iom.edu/Object.File/Master/63/122/America%27s%20Uninsured%206%20pager%20FINAL%20for%20web.pdf

[7] C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1, available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=schoen&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

[8] C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1.

[9] D. Rowland, "The Adequacy of Health Insurance," Testimony before the United States Senate Committee on Health, Education, Labor and Pensions, February 24, 2009, available at: http://www.kff.org/uninsured/upload/7870.pdf.

[10] C. Schoen, "Insurance Design Matters," Testimony before the United States Senate Committee on Health, Education and Pensions, available at: http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2009/Feb/Testimony%20Insurance%20Design%20Matters%20Underinsured%20Trends%20Health%20and%20Financial%20Risks/1240%20Schoen%20SenateHELP%20underinsured%20testimony%20Feb%202009.pdf.

[11] C.T. Robertson, R. Egelhof, and M. Hoke, "Get Sick, Get Out: The Medical Causes of Home Foreclosures," *Health Matrix*, 18 (2008): 65-105, available at: http://works.bepress.com/christopher_robertson/2

Growing Old Gracefully,
An Investigation into the Growing Number of Bankrupt Canadians over age 55

A research project funded by the Office of the Superintendent of Bankruptcy

March 31, 2006

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I. Introduction

For the past five years, the number of Canadians over age 55 who have declared bankruptcy has grown steadily. This is a troubling phenomenon, since presumably economic certainty and freedom would only be more likely in the later stages of life as habits of prudence are inculcated. Our inquiry seeks to explain the phenomenon, more specifically, to discern the causes for the rise of bankruptcy for the group of Canadians who have filed and are over age 55, both regionally and nationally. Our study has made a preliminary analysis of data collected by the Office of the Superintendent of Bankruptcy (OSB) for bankrupts filing from 2003-2005, augmented by a qualitative survey of consumer bankrupts that declared bankruptcy during this period. This project examined the growth in bankruptcies for those over age 55 from a legal, economic, social and philosophical perspective, allowing for a multidisciplinary investigation with research collaborators from the Faculty of Law, Department of Economics and Department of Philosophy at the University of British Columbia to assess the potential and limitations of the fresh start paradigm for older consumer debtors.

If one public policy objective is truly to allow our citizens to "grow old gracefully" by having social and economic security, we need to identify the factors that serve as barriers to realization of that goal and make policy recommendations that would ensure our social and economic instruments are responsive to the underlying causes of consumer bankruptcy.

II. Research Objectives

The principal objective of the study was to explore issues unique to consumer bankrupts over age 55 and, in particular, to discern the causes of bankruptcy nationally and regionally. It explored whether there were any gender issues associated with bankruptcy at an older age. Another objective was a qualitative survey of consumer bankrupts over age 55, to ascertain information about their experience with the bankruptcy system through in-person or telephone interviews.

A further objective, which will be the subject of a scholarly paper later this year, was an exploration of the adequacy of the current system to address over-indebtedness of aging citizens, undertaking a comparative analysis with similar trends in the United States. The goal is to provide meaningful analysis for insolvency administrators and legislators, to provide a better basis on which to consider revision to consumer bankruptcy legislation in Parliament's anticipated reform of the *Bankruptcy and Insolvency Act (BIA)* in 2006.

There were a number of research questions at the outset of the study. The data available allowed the investigators to answer some of those questions. Others were not possible to research given the current state of data collection in Canada and are discussed in our recommendations for further research and data collection at the end of this report. This report addresses the following research questions:

1. How is consumer bankruptcy being used as an economic adjustment tool for an increasingly aging Canadian population and is it the appropriate mechanism for relief of over-indebtedness for those that are approaching the limits of their income earning years?

2. What are the principal causes of bankruptcy for consumer debtors over age 55, explored in 5-year cohorts from age 55 to 74 and then for the group over age 75.

3. A sub-question of this inquiry is whether over-indebtedness is due to inadequate pension savings or the lack of social safety nets and, if so, are those no longer active in the workforce required to meet their basic needs through overuse of credit purchases or other credit facilities?

4. The OSB reports that there are considerable regional differences in the growth in the number of consumer bankruptcies. Are the numbers for those over age 55 increasing

at the same rate as the general population? If not, what factors are contributing to a higher or lower rate of growth?

III. Context for the Study

There has been a large increase in the number of consumer debtors that experience financial distress. The number of consumer bankruptcies in Canada has grown in the past 30 years from 6,271 bankruptcies in 1973 to 84,638 in 2005.[1] The total number of insolvencies, including both proposals and bankruptcies was 111,807 in 2005.[2] The average age of debtors who filed bankruptcy proceedings in 2004 was 42.5 years old, higher than the average age of the Canadian population, which was 38.3 years in 2004.[3]

In 1980, the insolvency rate was 1.1 per thousand Canadians; by 2004, that rate had quadrupled to 4.0 per thousand Canadians.[4] Comparing the Canadian rate of bankruptcy to other countries in 2004, the United Kingdom rate was 1.1 per thousand population; Australia was 1.8 per thousand; and the United States is 7.0 per thousand population.[5] Hence while Canada fares better than its neighbour to the south, its rates are much higher than the UK and Australia.

Scholars have attributed the rise in consumer indebtedness to the rapid growth in credit card availability and the ease of receiving credit facilities from manufacturers of consumer goods.[6] The downsizing of government and the financial failure of numerous large corporations, as well as the exportation of jobs to transition nations has also, arguably, had an impact on the financial security of Canadians. Many of our citizens that are approaching their retirement years were employed in the resource sector or the automotive sector, both of which have experienced fluctuations in economic activity and frequently, the shedding of long-term employment. Unlike the United States, in which there is considerable empirical analysis of consumer bankruptcy, in Canada, there has not yet been sufficient investigation into the underlying causes of consumer

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[1] Office of the Superintendent of Bankruptcy, http://osb-bsf.gc.ca, accessed March 2006.
[2] This was a 0.3% increase from 2004 to 2005; the OSB suggests that the slower rate of increase in the past year was attributable to low interest rates and better job creation performance; *ibid.*
[3] Office of the Superintendent of Bankruptcy, *An Overview of Canadian Insolvency Statistics*, (Ottawa: Industry Canada, 2006) at 3.
[4] *Ibid.* at 21.
[5] *Ibid.*
[6] Karen Gross, *Failure and Forgiveness; Rebalancing the Bankruptcy System*, (Yale University Press, 1997); Teresa Sullivan, Deborah Thorne and Elizabeth Warren, "Young, Old, and In-Between: Who Files for Bankruptcy?" (2001) 9 Norton Bank. Law Advisor; Teresa Sullivan, Elizabeth Warren and Jay Lawrence Westbrook, "The Fragile Middle Class: Americans in Debt" (2000); Daniel Skoler, "The Elderly and Bankruptcy Relief: Problems, Protections, and Realities" (1989) 6 Bank. Dev. J. 121.

bankruptcy. Analogously, there have been few efforts to reform public policy or information gathering that might address this recent trend.

There has also been a dramatic rise in the number of summary administration bankruptcies, where the net value of the estate is below $10,000. In 2002, 96.4% of bankruptcies administered by the OSB were summary administration bankruptcies. Roughly 85% of consumer bankrupts do not have surplus income over Statistics Canada Low Income Cut-offs that would be available to meet payments to creditors over a prescribed period. A working hypothesis for this study was that this percentage would be considerably higher for those over age 65. There has been a lack of empirical data on the causes underlying this level of financial distress.

Moreover, the exemptions of property in consumer bankruptcy vary considerably across Canada, because the provinces currently regulate them. Exemptions are designed to meet basic needs and to protect a limited number of apparel and furnishings, medical aids, limited equity in vehicles and tools of the trade from being brought into the estate and liquidated to satisfy creditors' claims. In some provinces, there is no exemption for equity ownership in housing, while in other provinces there are limited amounts, with little acknowledgement in the exemptions of the rising cost of living. Given that those over age 65 are less likely to require exemptions for tools of the trade but may have equity ownership in their homes as economic security, it may be that the current exemption scheme is inadequate to deal with the particular needs of aging consumers. Moreover, the issues faced by those aged 55-65 likely are quite different than those over age 65 or 75. Hence the study examined consumer bankrupts in the following age categories: age 55-59, 60-64; 65-69; 70-74 and age 75 and older, in order to ascertain a more reliable picture of what is occurring within these age groups.

The Senate Committee observed that the bankruptcy system is increasingly compromised for low-asset low-income debtors, but acknowledged that there needs to be more empirical evidence as to the precise effects of the system on this class of debtors. This study has commenced this investigation in respect of consumer debtors over age 55, but much more work is required in order to have a sufficient picture.

Another research objective was to make policy recommendations to the OSB as to ways in which the current data collection could be improved as the OSB moves toward greater electronic filing and statistics administration, which we propose throughout this report.

IV. Methodological approach

Given the limited amount of research funds available, the study concentrated on statistics of consumer debtors over age 55 for the past two years, with reference back for comparative periods where the information is available. The OSB currently has an electronic database of roughly 60,000 consumer bankruptcy files, and this project was aimed at retrieving and analysing the information related to those over age 55. The OSB has data on 7,997 consumer bankrupts over age 55 who filed in 2003-2005.

Stage 1: Analysis of 1,000 Representative Files

The first part of the study involved design of research fields for retrieval of electronic records, working with staff and economists at the OSB. The study then analyzed a sample of 1,000 cases of bankrupts to determine the causes of bankruptcy. One problem that currently exists with the electronic data is that there are not separately captured fields for cause of bankruptcy. Hence, the data on causes had to be manually pulled from the files, assessed in terms of the primary cause (self-declared) of bankruptcy and then entered into an Excel database. This was a very labour intensive task. A methodology for analyzing the data was developed, coding variables within cases on a consistent basis so that comparisons could be generated across age cohort and region.

One recommendation is that the OSB seriously consider revising its forms to begin to capture cause of bankruptcy data in different fields. The data collection tool should provide a way for bankrupts to indicate primary and secondary causes, where there are multiple causes. This would allow for empirical research on causes of bankruptcy across the entire population, including all bankrupts over age 55.

One limitation to analyzing this data was that there were instances in which bankrupts listed more than one cause of bankruptcy, for example, job loss combined with over-extension of credit. For purposes of this study, we took the declared primary cause, but it is important to note that there are frequently synergistic contributions to financial distress that are not captured when reporting global statistics.

Stage 2: Full Database

The project analyzed the full data set of 7,797 bankruptcy files with filing dates from 2003-2005 by retrieving data and undertaking analysis of the data by age cohort, region,

occupation, type and quantum of debt, asset level, income level and gender.[7] This allowed for global analysis of the data for which there are discreet fields, as discussed in parts V-VII of this report. While the data set was relatively complete, there were files in which fields had not been completed with information. Given that some data collection is relatively recent by the OSB, the completeness of the data is likely to be enhanced in the future.

One recommendation would be that the OSB set up its e-filing system so that the trustee cannot file the forms if particular fields are not completed, allowing the OSB to collect the most critically important data.

Stage 3: Qualitative Study

The objective of this part of the study was to design and conduct a qualitative survey by interviewing recent consumer bankrupts over age 55, aimed at enhancing the raw data. The qualitative study was undertaken in conformity with privacy legislation and university ethics approval. Given the age cohort, it was expected that most of the information would be gathered in telephone interviews; however an offer was made in the greater Vancouver area to conduct the interviews in person if the individual wished.

There were significant challenges for conducting the qualitative part of the study and the study encountered some difficulties in gathering the empirical data. The objective was originally 100 participants. The questions were formulated with the assistance of five trustees, who discussed their recent experiences with consumer bankrupts over age 55. There were 15 questions in the survey, set out below.

The ethics approval from the University of British Columbia took seven months, requiring three amendments to the application because of concern by the Ethics Board about the vulnerable nature of the survey group. When approval was granted, the conditions were very specific and limited. The research team was prohibited from following up on the initial letter and consent form with a telephone call, unless the consent had been mailed in. Since there is a much greater likelihood of participation when letters are combined with personal contact, this severely limited the number of possible participants in the survey. The Ethics Board declined to approve an accompanying letter from the OSB on the basis that the bankrupt person may feel pressure to cooperate given the involvement of the OSB. Our view, to the contrary, is that such a letter would have assisted in

[7] The data was generated on February 27, 2006 by the OSB.

reassuring older bankrupts of the value and legitimacy of the survey. The Ethics Board also declined to allow trustees, who work with bankrupts in part to alleviate the financial distress, to approach possible participants.[8]

The Ethics Board also required that the letter outlining the purpose and goals of the study had to specify that the survey would cause the participant stress. We conjecture that this may well have been a factor in the number of willing participants. Let us also note here that the interviewer (a trained graduate student) was not allowed to deviate from the 15 approved questions, even where a follow up question might have been warranted. We respect the importance of uniformity in the survey, but also believe that the process itself might have unearthed additional factors had more questions been admissible.

The Board also imposed a very high standard of confidentiality and protection of privacy requirements, which we deemed appropriate given the vulnerability of this population.

Once ethics approval was received, 400 letters were mailed to participants based on a random list by region generated by the OSB. The letters were accompanied by the questions that would be asked; a covering letter setting out the project, including names and contact numbers of the person surveying; consent forms; and self-addressed stamped envelopes. The study required that the covering letter include ethics department contact information for complaints about the survey.

Of the 400 letters sent, 81 letters returned as moved, a figure very high for an older population. This may reflect continuing financial uncertainty, although there is no clear evidence of this. Eight letters were returned by a family member, advising that the bankrupt had passed away. Ultimately, only 16 bankrupts agreed to be surveyed. As a result, the sample size is not significant enough to draw any firm conclusions. The small survey did, however, yield observations congruent with the findings of the 1,000 sample provided by the OSB, both in terms of the primary causes of bankruptcy and the causes of the recent increase in bankruptcies.

While not statistically significant, the qualitative survey did provide a texture to the electronically filed data, and so is included on that basis. Further consideration should be given as to whether additional qualitative study should be conducted, seeking

[8] Trustees have multiple roles in the Canadian bankruptcy system, including realization of assets for the benefit of creditors; assisting the debtor in filing bankruptcy; serving as a proposal trustee; and counselling bankrupts.

participation of a broader number of people in order to capture a sample that is statistically significant.

Survey questions:

1. What was the main reason for your bankruptcy?
2. Did you use your credit card to pay your utilities bills?
3. Did you use your credit card to pay for groceries?
4. Did you use your credit card to help your family?
5. Did you co-sign a loan for a family member?
6. If yes, you co-signed a loan for a family member, was it for a business? A car? A mortgage?
7. Were there any family related issues that caused the financial distress? (For example, child's loss of income, death of spouse?)
8. Were there costs for health care that led you to declare bankruptcy?
9. Did any social activities make your financial situation worse?
10. Was it difficult to tell family or friends about the bankruptcy?
11. If you had someone to talk to about your finances before the bankruptcy, would it have helped?
12. Did you have access to your pension savings before declaring bankruptcy?
13. If the bankruptcy was caused in part by a job loss, were you able to find employment again?
14. How long has it been since your bankruptcy and has your economic situation improved?
15. Is there anything else that you think would help us with our research in understanding why more people over age 55 are declaring bankruptcy?

V. Consumer bankruptcy as an economic adjustment tool

The study found that 63% of the total bankrupts over age 55 were age 55 to 65, indicating that this is a very high risk period for financial distress. While the causes of bankruptcy were not available for the entire data set, for the sample of 1,000 files, 16% of bankrupts in this age category reported job loss as the primary cause of bankruptcy. In most of these cases, the

bankrupt did not report new employment that generated surplus income within the meaning of the *BIA*.

Out of the 7,797 bankrupts over age 55, 28% of the total bankrupts over age 55 were between ages 65 and 74 and 8% were 75 and older. That 8% represents 624 people, a relatively high number for that age group.

Our analysis of the data suggests that consumer bankruptcy is increasingly used as an economic adjustment tool for the aging Canadian population. As the figures below will indicate in greater detail, credit card debt was very high across all age groups. More than 85% of bankrupts over age 55 held credit card debt, with a median credit card debt between $13,338 and $15,610. Bankruptcy appears to have been a mechanism to get out from under these large debts and the spiraling cycle of high interest rates and the inability to pay off the debt.

The issue of credit card debt has been studied by bankruptcy scholars in the United States. Elizabeth Warren observes that the profit margins of credit card issuers have increased substantially since the early 1980s and that during highly profitable periods, credit card companies are more likely to give credit cards to marginal borrowers and borrowers already loaded with debts because they increase their overall profits from the interest payments from these borrowers even though it also increases the default rate.[9] She cites economist Lawrence Ausubel's work, which found an extremely high rate of correlation between credit card defaults and bankruptcies in the United States.[10] Another study in the US found that credit card debt among indebted seniors (over age 65) increased by 89% between 1992 and 2001, with 73.7% of seniors holding credit card debts in 2001.[11]

While the figures are not directly comparable to Canadian figures, it does indicate that credit card debt is growing among older people and that there is likely a correlation between credit card debt and financial distress among those over age 55. Given the high interest rates on credit cards, older debtors who do not have an income stream to cover the interest rates are more likely to default on the credit card payments. Bankruptcy becomes a means of relieving the financial distress and having a "fresh start" in terms of the credit card debt.

The OSB data indicates that 15.3% of all individual bankrupts in Canada were over age 55 in 2003. In 1993 this figure was 6.9%; hence it has more than doubled in the past decade. At a

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[9] Elizabeth Warren, "The Bankruptcy Crisis" (1998) 73 Ind. Law Journal 1079 at 1083.
[10] *Ibid.*, citing Lawrence M. Ausubel, "Credit Card Defaults, Credit Card Profits and Bankruptcy" (1997) 71 Am. Bankr. Law Journal 249 at 250.
[11] Heather McGhee and Tamara Draut, "Retiring in the Red", Briefing Paper (New York: Demos, 2003).

time when it is expected that individuals will have accumulated sufficient assets to carry themselves through to their retirement years, this increase in the bankruptcy rate of Canada's aging population is of concern. The very nature of bankruptcy suggests that there are few assets remaining, those limited assets for basic needs that are exempt from seizure by creditors. Unlike younger consumer debtors that can utilize the bankruptcy provisions to shed onerous credit obligations and have a "fresh start" in terms of earning capacity, credit history and quality of life, older consumers, particularly those over age 65, are less likely to be able to recover economically and socially from the bankruptcy. The aging population and shifting social safety nets and familial supports are likely contributors to this trend, although we were not able to conclude that definitively from the data available.

A. Regional Rates of Bankruptcy

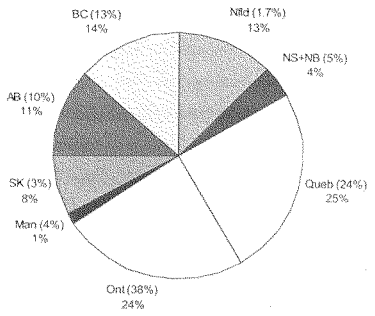
There are considerable regional differences in the growth in the number of consumer bankruptcies. The study examined whether the numbers for those over age 55 who were bankrupt were at the same rate as the general population.

Chart 1 illustrates the percentage of bankruptcies per province, compared with the percentage of general population in each province. Bankruptcy rates vary across provinces, with Newfoundland and Saskatchewan having proportionately more bankrupts than the percentage of overall population. Newfoundland has 1.7% of Canada's population, 1.6% of those over age 55 in Canada and yet has 9.5% of Canada's older bankrupts. Saskatchewan has 3% of Canada's population and 6% of the country's older bankrupts. Older Ontarians are less likely to be bankrupt, representing 38% of the population over age 55 and 24% of older bankrupts. Similarly, while Manitoba has over 4% of the Canadian population, it has only 1% of the bankrupts in this age group.

In contrast, in British Columbia, Alberta, Québec, Nova Scotia and New Brunswick, the percentage of bankruptcies over age 55 was within one percent of the percentage of population over age 65. Hence there were no regional discrepancies observed in two Maritime Provinces. By contrast, Newfoundland's bankruptcy rate for aging individuals far outstrips the other Maritime Provinces and Canada as a whole. The Nova Scotia and New Brunswick figures are particularly interesting because it flies in the face of the general perception that the entire Maritimes is economically depressed, with lack of jobs being a key feature of the economy.

Chart 1

Percentage of Bankruptcies per Province (share of population)



B. Sources of Debt

The full data set also generated information on the sources of debt, with credit card and mortgage debt comprising the largest source of financial pressure. More than 85% of the bankrupts held credit card debt, with a median credit card debt between $13,338 for bankrupts aged 55-59 and $15,610 age 75 and older.

Table 1, Sources of Debt, illustrates that the percentage of bankrupts with credit card debt increases as individuals get older and the amount of that debt also increases, notwithstanding the fact that the oldest individuals are unlikely to have employment income to meet these debts. One observation made by the trustees that assisted in framing the questions for the study is that often individuals who have successfully carried and paid off credit card debt during their employment years, do not adjust their standard of living or financial practices on retirement, and then find they are unable to pay the credit card debt.

Table 1 also indicates that 17% of bankrupts held mortgages, and the median value of mortgage debt lay in the range $48,140 to $66,452. While this figure raised the question of whether bankrupts were refinancing their homes as an economic survival strategy, we were not able to

answer this question with the data available. This would be important information to try to gather in future empirical study.

Only 3% of bankrupts owed individuals money and both the percentage of bankrupts and the amount owed steadily decreased with age. Only 2% of those over age 75 owed individuals, yet 90% of this group had credit card debt.

Overall, 32% of bankrupts over age 55 owed money to finance companies, with a median debt of $8,500. The median amount did not vary much across the age groups, except for those over age 75. 42% owed money to banks, and the median debt declined from $11,627 for the age 55-59 group to $7,700 for the 70-74 age group. It rose, however, to $9,569 for the over 75 group.

Table 1

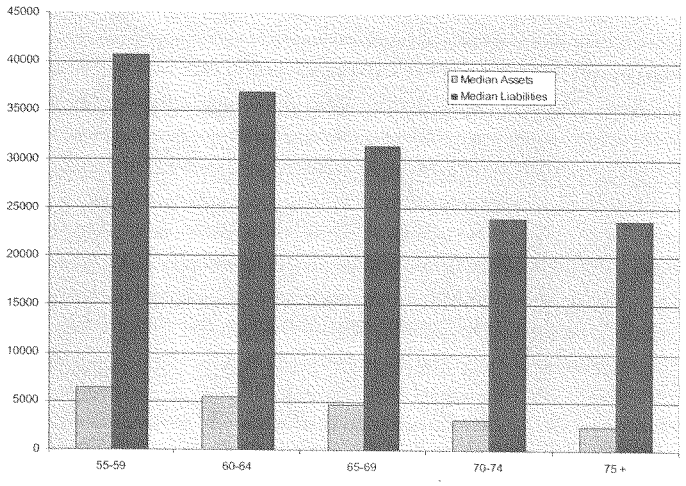
Sources of Debt

	Credit Cards		Mortgages		Bank Loans		Finance Co.		Individuals	
55-59	85%	13338	21%	66452	47%	11627	36%	9987	4%	9500
60-64	86%	14362	20%	56000	43%	10333	33%	8950	3%	5000
56-69	87%	13952	16%	48140	41%	9848	35%	8000	3%	4250
70-74	87%	13958	11%	65441	35%	7700	32%	8000	2%	6950
75 +	90%	15610	8%	53000	30%	9569	23%	5244	2%	4465

Another indicator that bankruptcy is being utilized as an economic adjustment tool is the ratio of assets to liabilities. Chart 2 indicates that there was a very high liability to asset ratio. The median level of liabilities declined monotonically from $40,796 for the 55-59 age group, to $23,739 for the over 75 age group. Similarly the median level of assets declined monotonically, but from $6,463 to $2,501.

Chart 2

Assets and Liabilities



C. Gender and Marital Status

55% of all bankrupts over age 55 were male and 45% were female. While one working hypothesis had been that an increased number of older women may be filing for bankruptcy because of inadequate income support during earlier years, these figures are similar to the gender breakdown for bankruptcies in all age groups in 2004 (55.5% male and 44.5% female).[12] Moreover, compared with general population figures, proportionately fewer women over age 55 are bankrupt, as they comprise 50.5% of the Canadian population, but only 45% of those over age 55 who file for bankruptcy.[13]

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[12] Office of the Superintendent of Bankruptcy, *An Overview of Canadian Insolvency Statistics*, (Ottawa: Industry Canada, 2006) at 3.
[13] Statistics Canada, *Labour Force Survey*, cited in *ibid*. at 3.

By far the majority of bankrupts over age 55 were married. Charts 3 and 4 illustrate that more than 3,000 bankrupts in this age group were married, 40% of all those over age 55. Another 5% were living common law with a partner. Over 15% were widowed at the time of filing and 20% were divorced.

Chart 3 Marital Status- total numbers

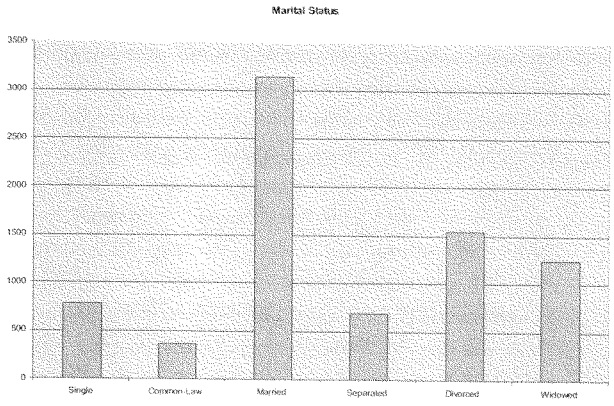
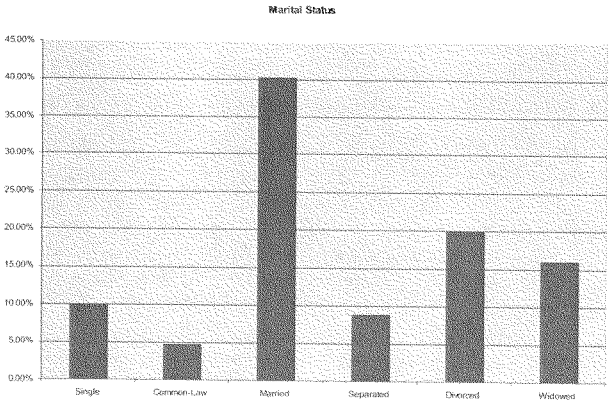


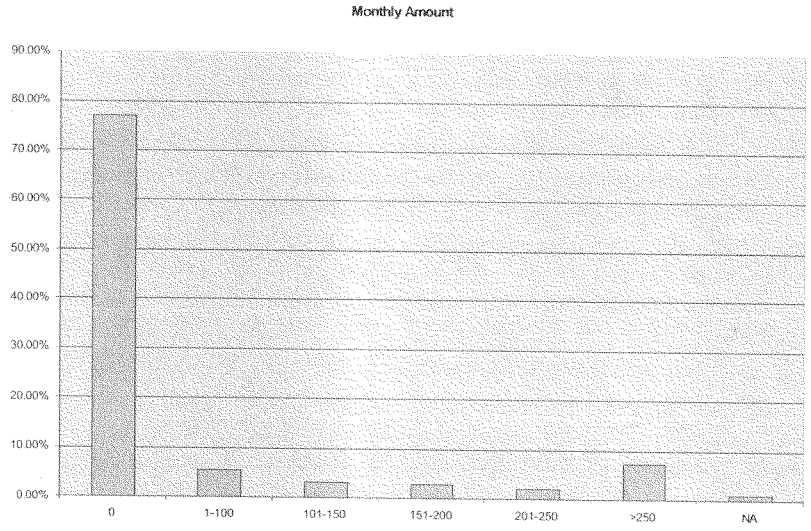
Chart 4 Marital Status- by percentage



D. Surplus Income Payments

As Chart 5 illustrates, almost 80% of those over age 55 did not have the resources to make surplus income payments. This reflects figures nationally, but interestingly, was not higher than the national figures for all age groups, as originally anticipated. The rate is interesting because the earning potential of a number of these people would be limited, depending on their age or health. Those who were or are making surplus income payments at the various dollar amounts, vary, but never reach 10% of the group studied.

Chart 5 Surplus Income Payments



VI. Sample of 1,000 Files of Bankrupts over Age 55

As noted in the introduction, the current electronic database of the OSB does not capture separate fields for causes of bankruptcy. As a result, data in this study is drawn from 1,000 files of bankrupts over age 55, pulled randomly from across all regions. The reported causes of bankruptcy had to be manually extracted from the files, and then a method of standardizing the reported causes and inputting the data developed. There was a fair degree of consistency in how

causes of bankruptcy were reported by individual bankrupts. However, it is important to note that while the individual completes the form declaring cause of bankruptcy, he or she may be influenced by the trustee's advice on how to report causes. While this may assist in a degree of uniformity, there is also some risk of less than full accuracy of reporting, as there is no standardized definition of how causes are to be reported. One recommendation to the OSB is that it consider providing a more standardized list of causes of bankruptcy, which could then be collected in separate electronic fields at the time of bankruptcy filing.

A. Sources of Debt

For comparative purposes, Table 2 provides a comparison of some of the sources of debt for the 1,000 sample population. It illustrates total liabilities and credit card debt across the entire sample of 1,000 bankrupts, analyzing the mean, minimum, maximum, and 25^{th} and 75^{th} percentiles. The median was taken as the most accurate picture of liabilities. Note that there was one debt at over $41 million in the age 70 to 74 category, which skews the average debt upward in that age group to $333,510. Yet the median debt for that age group was $28,061. By using the median, the study was able to draw a clearer picture of how total liabilities are reflected by age group.

Table 2 indicates that the median amount of liabilities steadily declines by age group, but that bankrupts age 70-74 and over age 75 continue to have a median debt of $28,061 and $24,942 respectively. Credit card debt thus figures very prominently in bankruptcy among the aging population. Whereas overall debt decreases as individuals are older, the amount of credit card debt increases, with a median of $18,713 for the over age 75 group, more than ¾ of their debt at the time of bankruptcy. In contrast, credit card debt is only about one third of the total liabilities of bankrupts aged 55-59.

This indicates that credit card debt rises when other fixed financing commitments, such as bank loans or mortgages are paid down. Since credit card debt does not require the guarantees, assets or income assurance that banks and other lenders require for more traditional loans, it is easier for debtors to acquire debt on credit cards at this age, possibly creating the wrong incentive effects. The credit card debt becomes proportionately higher as an individual ages.

Table 2 Comparison of Total Liabilities with Credit Card Debt

Total liabilities

age group	mean	min	5th percenti	median	75th %ile	max
55-59	112,128	3,018	21,596	38,191	88,722	6,615,700
60-64	67,624	2,506	18,333	36,848	70,143	1,617,863
65-69	51,995	5,299	16,751	31,325	57,698	470,977
70-74	333,510	4,881	15,391	28,061	47,972	41,272,776
75 +	35,108	5,030	14,796	24,942	44,281	180,023

Credit Cards

age group	mean	min	25th %ile	median	75th %ile	max
55-59	19,733	100	6,492	12,398	23,174	206,221
60-64	19,462	333	6,681	13,569	24,170	149,851
65-69	18,716	270	7,336	13,384	23,314	124,835
70-74	17,908	472	7,391	13,929	23,370	133,938
75 +	22,713	367	9,631	18,713	27,457	91,838

Comparing the same total liabilities with private loans, one sees the same pattern. Whereas overall debt decreases as individuals are older, the amount of loans from private individuals increases. Both tables 2 and 3 analyze only those who have the credit card debt (85%) and those that have private loans (3%).

Table 3 Comparison of Total Liabilities with Private Loans

Total liabilities

age group	mean	min	25th %ile	median	75th %ile	max
55-59	112,128	3,018	21,596	38,191	88,722	6,615,700
60-64	67,624	2,506	18,333	36,848	70,143	1,617,863
65-69	51,995	5,299	16,751	31,325	57,698	470,977
70-74	333,510	4,881	15,391	28,061	47,972	41,272,776
75 +	35,108	5,030	14,796	24,942	44,281	180,023

Loans from Individuals

age group	mean	min	25th %ile	median	75th %ile	max
55-59	19,382	765	1,800	8,300	24,000	105,000
60-64	8,945	1	3,000	7,500	10,000	30,000
65-69	13,421	1,400	2,000	2,500	8,206	53,000
70-74	44,318	4,500	4,500	19,500	108,953	108,953
75 +	10,490	6,479	6,479	10,490	14,500	14,500

B. Causes of Bankruptcy

Chart 6 illustrates the causes of bankruptcy over the entire 1,000 sample. Overall, 29% of bankrupts over age 55 reported over-extension of credit as the primary cause of bankruptcy.

15% declared medical reasons the primary cause, although it was unclear from the data whether this was the costs of care over and above the Medicare system or income loss due to medical reasons, or some combination of both.

Elizabeth Warren and Melissa Jacoby, looking at the situation in the United States, have suggested that when medical reasons are cited as a cause of consumer bankruptcy, the normal case is attributable to some combination of causes, specifically, direct health care costs, loss of income due to medical problems or loss of income due to caregiving responsibilities in connection with medical problems.[14] In the files studied in this project, a number of those citing medical reasons as the principal cause also cited loss of employment income; hence there is likely some linkage there.

12% overall reported insufficient income as the primary cause, while 11% reported loss of employment income. 9% reported money mismanagement. 4% attributed the financial distress to marriage breakdown. The "other" 13% in Chart 6 represents the following primary reported causes of bankruptcy: fraud less than 1%; the cost of moving 0.5%; gambling 2.44%; inadequate pension 2%; failure to pay taxes 3.6%, financial support of a child 1.6% and miscellaneous other 1%.

7% reported involvement in a failed business as the primary cause. This number could be low, given how the OSB defines consumer and business bankruptcy in its statistics. Consumer bankruptcy is defined as individuals with more than 50% of liabilities related to consumer spending. Business bankruptcy includes not only corporations, but individuals whose commercial debts account for more than 50% of the total value of debts.[15] Hence a sole proprietor or person with a business that fails, leading to both personal and commercial financial crisis, is counted as a business bankruptcy if the commercial debts are 50% or more of the debts. A number of these

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[14] Melissa Jacoby and Elizabeth Warren, "Beyond Hospital Misbehavior; An Expanded Account of the Financial Consequences of Illness or Injury" (Working Paper, 2005), which found that over 80% of medical filers reported income loss as contributing very much or somewhat to their bankruptcies.
[15] Office of the Superintendent of Bankruptcy, *An Overview of Canadian Insolvency Statistics*, (Ottawa: Industry Canada, 2006) at 1.

individuals with failed businesses are therefore likely to be included in those statistics. The OSB reports that of 9,856 business insolvencies in 2004, 7,075 were sole proprietorships.[16]

Chart 6 Causes of Bankruptcy – Reported Primary Cause

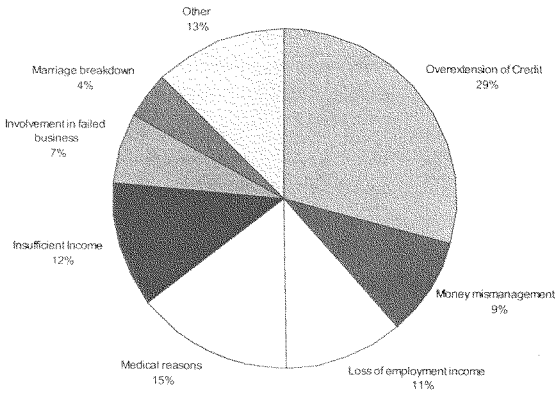

Table 4 analyses the causes of bankruptcy by age group for the 1,000 bankruptcy sample. There are a number of significant statistics. Overextension of credit is a huge contributing factor across all age groups, and particularly significant among older bankrupts. The overextension of credit rises steadily as the principal reason for bankruptcy. 26.50% of those aged 55-64 report it as the primary cause of bankruptcy, compared with almost 36% of those aged 70-74 and almost 40% of those over age 75.

Loss of employment income is very significant for the age 55-59 group, with almost 16% declaring loss of employment as the primary reason for their bankruptcy. This rate is better for those aged 60-64 and 65-69, with 11.73% and 10.70% declaring loss of employment income as the primary cause of bankruptcy, although it is still surprisingly significant given what was previously a standard age of retirement at age 65. While the percentage drops at age 70-74 to

[16] OSB, *Insolvencies in Canada 2004*, http://strategis.ic.gc.ca/epic/internet/inbsf-

8.39%, this is still relatively highly, particularly when there is an expectation at this age that job loss is not going to be a factor in one's financial health.

As noted above, medical reasons are quite significant as a primary cause of bankruptcy. Of note is that medical reasons are more significant for the younger age group and decline monotonically as one grows older. Medical reasons are the primary cause of bankruptcy for 15.59% of those aged 55-59; 15.96% for those aged 60-64, but dropping to only 10.78% for those over age 75. One explanation for this may be that senior citizens have greater access to drug coverage, health care and home care as they age, whereas some of the economic burden of those costs would fall more directly on the shoulders of those aged 55-64.

Another significant statistic in Table 4 is the high percentage of bankrupts aged 55-64 declaring involvement in a failed business as the primary cause of bankruptcy. As noted earlier, the OSB statistics report that there were 9,856 business insolvencies in Canada in 2004, including 2,781 corporations and 7,075 sole proprietorships.[17] There is likely a spillover effect in that a number of individuals end up declaring personal bankruptcy after their business or the company that employed them failed. Moreover, even if an individual files for business bankruptcy, a spouse or common law partner might also file a personal bankruptcy during the same period in light of the failed business and resultant financial distress for the family. It would be useful in the future if the OSB could cross-reference business failure with consumer bankruptcies by asking the consumers that file to indicate the name and date of the failed business, and whether they were an employee, principal owner, director or officer of the business.

Money mismanagement was reported as the primary cause in 6.24% of bankrupts aged 55-59; and 9% to 11.5% for all other age groups. It is difficult to draw any conclusions from this statistic, although it may be evidence that at least in a number of cases, counselling regarding financial management is of some assistance.

Finally Table 4 illustrates that marriage breakdown is a significant cause for bankruptcy in the younger age categories; for those aged 55-59, 5.79% reported marriage breakdown as the primary cause and for those aged 60-64, 5.19% reported marriage breakdown as the primary reason for their bankruptcy.

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osb.nsf/en/br01476e.html.

[17] OSB, *Insolvencies in Canada 2004*, http://strategis.ic.gc.ca/epic/internet/inbsf-osb.nsf/en/br01476e.html.

Table 4

Primary Causes of Bankruptcy

Reported – By Age

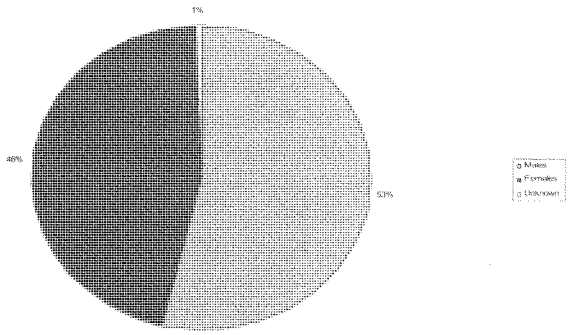
	55-59	60-64	65-69	70-74	75+	All
Overextension of Credit	26.50%	25.77%	27.68%	35.66%	37.75%	29.21%
Money mismanagement	6.24%	9.23%	11.49%	11.19%	10.29%	9.39%
Loss of employment income	15.81%	11.73%	10.70%	8.39%	4.90%	11.24%
Medical reasons	15.59%	15.96%	16.45%	11.19%	10.78%	14.66%
Insufficient Income	10.24%	11.35%	13.05%	11.19%	15.20%	11.83%
Costs of moving	0.45%	0.96%	0.26%	0.35%	0.49%	0.54%
Involvement in failed business	7.35%	8.65%	6.53%	4.90%	3.43%	6.73%
Gambling	2.23%	2.50%	2.87%	2.10%	2.45%	2.44%
Pension not sufficient	1.11%	1.35%	1.31%	3.85%	1.96%	1.74%
Marriage breakdown	5.79%	5.19%	3.39%	1.75%	4.41%	4.34%
Failure to pay taxes	3.12%	3.27%	3.13%	5.24%	3.92%	3.58%
Financial support of child	1.56%	1.73%	1.31%	1.40%	2.45%	1.63%
Fraud	1.11%	0.38%	0.52%	1.40%	1.47%	0.87%
Other	2.90%	1.92%	1.31%	1.40%	0.49%	1.79%

C. Causes of Bankruptcy by Gender

The gender breakdown of the sample of 1,000 was roughly the same as the gender breakdown among the entire population of bankruptcy over age 55, with 53% of bankrupts being male, 46% female and almost 1% unknown. As noted earlier, the entire universe of data examined, 55% of the bankrupts were male.

Chart 4

Breakdown of Bankruptcy by Gender



Examining the causes by gender, the principal reason for bankruptcy was overextension of credit for both women and men, 34% and 31% respectively for the 1,000 cases studied. Insufficient income was cited as principal reason for women in 14% of cases, compared with 9% for men. Given that women continue on average to earn only 60% of the income of males in the Canadian workforce, this statistic is not particularly surprising.

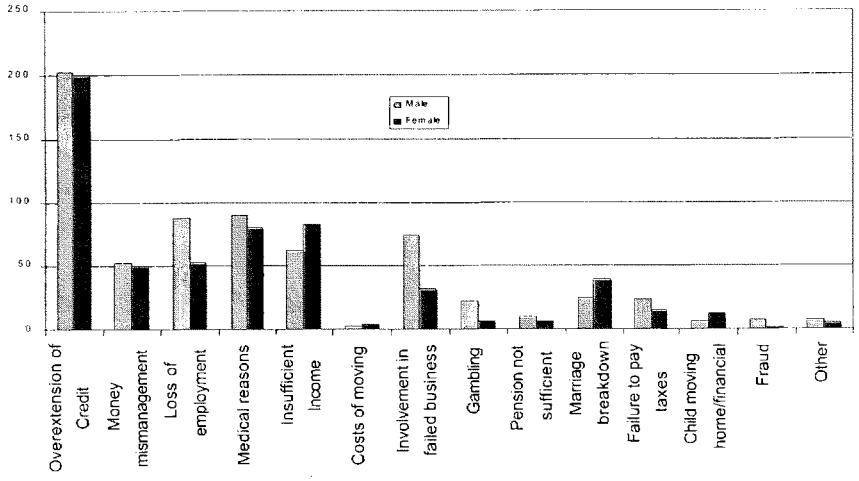
Loss of employment income was cited as principal reason for women in 9% of cases, compared with 13% for men, significant in both cases given the age cohort. Yet while women are less likely to cite job loss as the primary cause of bankruptcy, they are considerably more vulnerable to bankruptcy even with employment income, since a lower on-average income increases the appeal of bankruptcy as a fresh start opportunity.

Men were far more likely to be involved in a failed business, which then led to their bankruptcy. Involvement in failed business cited as principal reason for women in 5% of cases, compared with 11% for men, more than double the rate for women.

There were comparable figures in money mismanagement (8% for both) and medical reasons (14% and 13%). Marriage breakdown was a cause more frequently for women than men.

Chart 5

Causes of Bankruptcy by Gender



D. Causes of Bankruptcy by Region

Table 5 sets out causes of bankruptcy by region, illustrating that there are significant regional differences.

Table 5

Causes of Bankruptcy
Provincial and Regional Breakdown

Causes by Province	Maritime	Quebec	Ontario	Man	Sask	Alta	BC	All
Overextension of Credit	47%	29%	28%	40%	29%	31%	27%	32%
Money mismanagement	6%	9%	8%	5%	14%	9%	5%	8%
Loss of employment income	9%	8%	13%	5%	13%	12%	15%	11%
Medical reasons	6%	15%	14%	30%	7%	18%	16%	13%
Insufficient Income	16%	17%	11%	5%	4%	7%	6%	11%
Costs of moving	1%	0%	0%	0%	2%	1%	1%	1%
Involvement in failed business	7%	6%	10%	0%	12%	7%	12%	8%
Gambling	1%	3%	3%	0%	5%	2%	1%	2%
Pension not sufficient	1%	1%	3%	0%	1%	0%	2%	1%
Marriage breakdown	3%	5%	5%	5%	4%	5%	7%	5%
Failure to pay taxes	1%	3%	3%	5%	4%	3%	5%	3%
Financial support of child	0%	1%	1%	0%	4%	3%	2%	2%
Fraud	1%	1%	1%	0%	1%	1%	0%	1%
Other	1%	2%	0%	5%	0%	1%	1%	1%

Nationally, the top four causes of bankruptcy are: 32% report overextension of credit as the principal cause of bankruptcy; 13% report medical reasons; 11% report insufficient income as the principal reason; 11% report loss in income and 8% report involvement in a failed business.

The national figures are compared with the top four causes of bankruptcy by region, set out below. While overextension of credit tops the list in all regions, it is particularly significant in the Maritimes, cited as the source in 47% of cases. Medical reasons are the second top cause of bankruptcy in all regions except Québec and the Maritimes, where insufficient income is cited as second top cause.

Highlights by region of the top four reported causes of bankruptcy:

British Columbia
27% over-extension of credit
16% medical reasons
15% loss of employment income
12% involvement in failed business

Prairies:
31% over-extension of credit
15% medical reasons
12% loss of employment income
11% money mismanagement

Ontario
28% over-extension of credit
14% medical reasons
13% loss of employment income
11% insufficient income

Québec
29% over-extension of credit
17% insufficient income
15% medical reasons
9% money mismanagement

Maritimes:
47% over-extension of credit
16% insufficient income
9% loss of employment income
7% involvement in failed business

VII. Qualitative Survey

As noted in the discussion on methodological challenges for surveying a vulnerable population, the study was able to interview only 16 people of the 400 contacted, hence the sample does not provide any empirically value information. The 16 people interviewed were from Ontario (4), British Columbia (3), Québec (2), Newfoundland (4), Alberta (1), Manitoba (1), and Saskatchewan (1). Both Québec interviews were conducted in French.

Notwithstanding the fact that there is no statistically significant information, given the nature of the responses, it is helpful to provide the highlights as they provide a texture to the data. In the future, it would be helpful to consider whether this data could be collected when individuals are still in the bankruptcy process, through trustees or staff of the OSB.

Over extension of credit, medical reasons and insufficient income were principal reasons for the bankruptcy, which aligns with the data set of 1,000 bankrupts. More than half of those interviewed used their credit card to pay utilities bills on a regular basis. Although not statistically significant, this was an important insight that may help to explain why credit card debt is so high among older people. Similarly, 37.5% used a credit card to pay for groceries several times per month within the preceding year. It would seem that credit card debt, at least in this small sampling, plays a number of roles that it traditionally has not in a prior generation, and that individuals are paying extraordinarily high interest rates for goods and services that could be viewed as necessities.

31% had used the credit card in the two years prior to bankruptcy to help family members, which aligned with information that we had gathered from trustees, but which did not appear in our data analysis. 25% had co-signed a loan for a family member in the two years prior to their bankruptcy. 50% of those loans were for a mortgage and remainder for business loan for a family member. Of those signing for a business loan for a family member, all had signed a loan for a child and more than two-thirds reported that the business had failed.

31% cited family related issues that caused the financial distress. In some cases, individuals talked about children losing employment and moving back home (4 cases), while one was not specific. 19% reported that health care costs contributed to financial distress, but only 12.5% said it was the principal cause of bankruptcy.

Of the 31% that reported that the bankruptcy was caused in part by a job loss, more than three-quarters were not able to find employment again. When asked if any social activities made their financial situation worse, 31% reported that home shopping channel, casino visits, lottery tickets or on-line poker influenced their financial situation. This information may flag that further study needs to be undertaken as to the role of social activities in bankruptcy. While one working hypothesis of the study was that gambling was on the increase among older bankrupts, gambling as the primary cause of bankruptcy was, in the 1,000 sample, not significant as it was reported as the primary cause of bankruptcy in only 2.44% of cases.

75% reported that the bankruptcy had brought financial relief, although the economic situation had not really improved for over 56%. This is of concern in thinking about the fresh start philosophy for seniors.

100% of those surveyed said that it was difficult to tell family or friends about the bankruptcy, some discussing at quite length feelings of shame, fear and humiliation, particularly in having to

tell their children. 25% responded that if they had someone to talk to about finances before the bankruptcy, it would have helped.

VIII. Conclusion and Further Research

Presumably habits of spending and money management are inculcated long before the age of 55, and that if anything, financial planning at an earlier age helps to reduce the risk of shortfalls in retirement or the approach thereof. The rise of bankruptcy thus calls out for explanation. Possibly there are new temptations; shopping channels or gambling, or the imprudence of children enlisting the financial aid of parents forge two of our working hypotheses. But neither was borne out by this preliminary study. Only 2.44% reported gambling as the principal reason for bankruptcy, yet trustees had reported that the incidence seems much higher. It may be that there is a stigma attached to gambling such that it is not easily declared as the reason. Only 2% report children moving back home or financial support of children as the principal reason for bankruptcy, although here again, a limited sampling of trustees had indicated that in their observation this trend is on the rise.

One question the study had hoped to explore was the percentage of consumer bankrupts that are prejudiced by not having their RRSPs protected from seizure for the benefit of creditors, compared with those who have the exemption protection for their registered pension plans. Currently under the *BIA*, benefits from registered pension plans and RRSPs associated with life insurance policies are generally exempted from seizure. However, RRSPs held by banks, brokerages or self-directed RRSPs are not exempt from seizure. With the move in Canada from defined pension plans to defined contribution plans and the practice of encouraging employees to invest in self-directed RRSPs, our bankruptcy policy and pension policies may be failing to align in terms of protection for aging debtors.

The Senate Committee recognized this problem and recommended exempting RRSPs from seizure, while acknowledging that this would reduce the moneys available for distribution to creditors. This has been recognized in part in c. 47, amending the *BIA*, not yet proclaimed in force. Unfortunately, the study did not shed any light on the question of the current mix of registered pension and RRSP assets that are treated differently in consumer bankruptcy. In part, this was due to the way in which the data is collected. The OSB may wish to consider separating out different kinds of pension savings, in order to document this information in the future.

It was also unclear from the study as to whether current exemptions of property from seizure for all bankrupts appropriately reflect the needs of older debtors; and whether we need to consider public policy reforms that assess basic needs differently for older citizens. This information could not be analysed using the data available, but should be studied by the OSB in the future.

Finally, the OSB should consider further qualitative study through interviews. While the information is difficult to obtain, it dramatically enhances the quantitative statistics. Design of any future such study would, however, have to take account of the issues raised by university ethics boards in terms of how to acquire the information from a population that is particularly vulnerable.

The data in this report only provides a small glimpse into the economic, legal, social and philosophical factors that are important to understanding over-indebtedness or bankruptcy of older consumers. A better understanding of these dynamics is required before one can assess whether there particular policies or strategies that could be deployed to address or prevent financial distress in this age cohort. One question that requires further exploration, but which was not possible for this report, is whether bankruptcy is the appropriate mechanism for relief of over-indebtedness for those that are approaching the limits of their income earning years.

Medical Bankruptcy: Myth Versus Fact

This response to a widely cited paper by David Himmelstein and colleagues challenges the basis of its conclusions.

by David Dranove and Michael L. Millenson

ABSTRACT: David Himmelstein and colleagues recently contended that medical problems contribute to 54.5 percent of personal bankruptcies and threaten the solvency of solidly middle-class Americans. They propose comprehensive national health insurance as a solution. A reexamination of their data suggests that medical bills are a contributing factor in just 17 percent of personal bankruptcies and that those affected tend to have incomes closer to poverty level than to middle class. Moreover, for national health insurance to have an impact, it would have to define "medical" expenses in a much broader way than is now typical of either private or government-funded plans. [*Health Affairs* 25 (2006): w74–w83 (published online 28 February 2006; 10.1377/hlthaff.25.w74)]

The great enemy of the truth is very often not the lie—deliberate, contrived and dishonest—but the myth: persistent, persuasive and unrealistic.
—President John F. Kennedy, Commencement Address at Yale University, 11 June 1962.

IT IS NO SECRET THAT BAD HEALTH AND BAD DEBT often coincide. Unexpectedly large medical bills can impose a sizable burden on those who are already physically and economically fragile. In some cases, medical debt can contribute to a collapse of creditworthiness that forces some people to declare personal bankruptcy.

David Himmelstein and colleagues contend that this scenario is pervasive. "Medical problems contribute to about half of all bankruptcies," they write.[1] They warn that "solidly middle-class Americans...face impoverishment following a serious illness," and they propose a solution: comprehensive national health insurance such as that offered in Canada and Western Europe.

The authors' research credentials and prestigious affiliations; the genuine human tragedy of illness and bankruptcy; and the attention given to their findings by the news media, policymakers, and researchers have helped make their conclu-

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DOI 10.1377/hlthaff.25.w74

sions "persistent and persuasive," to use former President Kennedy's formulation.[2] Unfortunately, a closer examination of their paper suggests three reasons why their conclusions are also unrealistic.

First, they fail to provide a causal relationship to support the claim that medical spending contributes to "half of all bankruptcies" (54.5 percent). Our analysis of their data finds a causal link in only 17 percent of personal bankruptcies. Nor do their data support their contention that "solidly middle-class Americans" are threatened. Four decades of studies that have explicitly addressed the bankruptcy–medical spending connection lend credibility to our conclusion. These studies, which we discuss below, support a much smaller figure than half, as does a more recent national consumer survey sponsored in part by the Harvard School of Public Health.[3] As for the "solidly middle-class" citizens who face "impoverishment," Himmelstein and colleagues report an average household income of $25,000 for their respondents—a level more accurately characterized as "marginally middle class."

Second, the authors' methodology does not provide a definitive answer to the policy question they implicitly pose: how national health insurance would affect the rate of personal bankruptcy. At best, they show that medical bills are a cause of 17 percent of bankruptcies but are not necessarily the most important cause. They fail to perform the multivariate statistical analysis necessary to determine the magnitude of the causal relationship or to rule out other factors such as loss of job, education expenses, or housing costs. Indeed, an economic study cited by Himmelstein and colleagues concludes (in a portion they did not mention) that there is little support for the theory that households file for bankruptcy when "adverse events"—including health problems—reduce their ability to repay debts.[4]

Lastly, their suggestion that national health insurance would greatly reduce the number of bankruptcies linked to medical spending is misleading. They acknowledge that the impact would depend on the "comprehensiveness" of the plan. Our analysis shows that "comprehensiveness" in this context would require defining "medical" expenses in a way that is much broader than is now typical of either private or government-funded plans.

Background

Traditionally, many physicians charged little or nothing to treat those who possessed little or nothing. Hospitals continued the charitable tradition, albeit sometimes with a twist. In early-nineteenth-century America, poor patients were expected to begin working off their debt as soon as they were ambulatory. At New York's Bellevue Hospital, for example, "expectant mothers...scrubbed floors within hours of delivery."[5]

Modern health insurance originated during the Great Depression. As hospitals and physicians saw their income plummet, they began to accept the idea of reliable third-party payment through health insurance. Post–World War II advances in

medical technology and the expense of those advances prompted the public to clamor for reliable coverage. The result was widespread diffusion of health insurance as an employee benefit and the passage of Medicare for the elderly and Medicaid for the indigent.

Health insurance initially focused on catastrophic expenses. Over time, benefits increased, and consumer cost sharing shrank. Rising medical costs, coupled with recent increases in consumer cost sharing, are raising the anxiety level of the middle class. For example, for married-couple families with children, health spending rose three times faster than income between 2000 and 2003, absorbing half the growth of their income.[6] The addition of a Medicare outpatient drug benefit on 1 January 2006 will lower out-of-pocket spending for the average senior; however, some elderly people, including some who are chronically ill, may find that sizable medication expenses continue to accumulate.[7] Medicaid's budget woes are even more pronounced, as states restrict benefits or tighten eligibility requirements.

Private employers' spending on employee health benefits, meanwhile, jumped 51.4 percent from 1998 to 2003, to $330.9 billion.[8] As economic theory would predict, employers are responding by holding the line on salaries; real wages and salaries declined in 2004 by about 1 percent, while overall benefit expenses increased 3.5 percent.[9] Employers are also requiring employees to make larger contributions to premiums and cutting back on the retiree medical coverage that has been a critical supplement to Medicare. As benefits costs have risen, the percentage of full- and part-time employees covered by and participating in employer-sponsored health insurance has declined, from 53 percent in 1999 to just 45 percent in 2003.[10] Simultaneously, the hiring of new permanent employees appears to have slowed.[11]

As a result of these trends, the potentially dire consequences of large medical bills is a topic of acute interest to millions of Americans. The two broad policy questions underlying Himmelstein and colleagues' paper are important: What is the impact of the rising consumer share of medical costs, and what changes to our health insurance system could alleviate the financial burden of medical care? However, the specific questions they addressed are narrower: To what extent do high medical bills precipitate personal bankruptcy, and to what extent is a Canadian-style health care system a likely solution to such a problem?

What Himmelstein And Colleagues Found

Himmelstein and colleagues surveyed 1,771 people who filed for personal bankruptcy in 2001. They also interviewed 332 debtor households (in part to put a human face on the problem), but these interviews did not contribute to the computation of the number of medical bankruptcies. Thus, we focus on the survey.

They summarized the responses in Exhibit 2 of their paper, which is organized in three sections. The first section reports the percentage of households who cited

one of the following as a specific reason for their personal bankruptcy: illness or injury; a birth or death in the family; and problems with alcohol, drugs, or gambling. This is the only part of their survey where one might infer a causal relationship between medical problems and bankruptcy. The most frequently cited reason for bankruptcy is illness or injury, cited by 28.3 percent of respondents.

The second section of Exhibit 2 reports the number of respondents who had a variety of medical-related problems, such as illness causing a loss of at least two weeks of income, and medical bills in excess of $1,000 in the previous two years. The authors counted these as medical-related reasons for bankruptcy even if the respondents did not state that illness or injury was a reason for bankruptcy. They thus concluded that 54.5 percent of respondents had medical bankruptcies.

Criticisms Of Himmelstein And Colleagues' Analysis

Not long after the online publication of Himmelstein and colleagues' paper in February 2005, a conservative critique of it quickly appeared in *National Review Online*, while additional criticism and praise appeared in the eLetters section of *Health Affairs*.[12] Most of the criticism centered on the definition of *medical bankruptcy*, particularly the inclusion of people reporting medical bills exceeding $1,000 over a two-year period. Critics say that many of these people might have paid their medical bills well before another event (such as the loss of a job) precipitated bankruptcy. Himmelstein and colleagues offered two responses. First, they noted that average medical bills for this group exceeded $11,000, a figure that seems to show that outstanding medical bills were burdensome. However, the average of $11,000 might have been influenced by a few outliers. For example, Leslie Conwell and Joel Cohen report that 20 percent of Americans spent more than $3,200 on health care in 2002 but that just 5 percent spent more than $11,500.[13] Even so, the latter small group accounted for half of all U.S. expenditures. It would be more informative to know the median and other percentiles of the distribution of spending by the respondents to Himmelstein and colleagues' survey.

Second, Himmelstein and colleagues agree that some respondents might have paid off their medical debts, but they argue that without medical debts, respondents would have had more money available to pay other expenses. They also argue that the level of medical debt might have been understated, because some medical expenses might have been paid by credit card. The first argument could be made for all expenditures prior to bankruptcy, leading to the meaningless conclusion that all expenditures are responsible for all bankruptcies. The second argument merely reinforces the fact that since all debts are fungible, it is inappropriate to single out any one form of debt as the proximate cause of bankruptcy.

Data from the U.S. Census Bureau demonstrate the broader financial problems facing many lower-income Americans. In two years, a U.S. household with annual income of $22,000–$40,000 will spend an average of $20,000 on housing, $9,000 on food, $8,000 on transportation, $2,500 on clothing, and $4,500 on health care.

This income level is comparable to the average income in Himmelstein and colleagues' sample and is most accurately characterized as "marginally middle class," rather than the authors' "solidly middle class" characterization. Census Bureau data show that a household annual income of $25,000 is closer to the poverty level for a family of four (a little above $18,000 in 2002) than to the median U.S. household income (about $44,000 that year).

For most households in the $22,000–$40,000 income range, health care spending amounting to a few thousand dollars in the two years prior to bankruptcy would represent just the tip of the iceberg threatening to sink their creditworthiness. They have many other bills to pay. Moreover, it would be reasonable to budget for at least some health care expenses. Health care spending of a few thousand dollars might be unpredictable in its timing but not in its likelihood of occurring.

Moreover, although historical comparisons should be used cautiously, studies since the mid-1960s have consistently concluded that medical bills are a relatively minor part of the debt problem.[14] More recently, a study in Cincinnati of bankruptcy filers seeking Legal Aid Society assistance in 2000–2001 found that 47 percent had "substantial" medical debt but that medical debt accounted for just 12 percent of their debt total.[15]

This past year, the U.S. Department of Justice (DOJ) responded to a request by Sen. Charles Grassley (R-IA) by examining 5,203 bankruptcy cases from the files of the U.S. Trustee Program. The filings occurred between 2000 and 2002, the same time frame as the filings studied by Himmelstein and colleagues. The DOJ reported that 90 percent of filers had medical debt of less than $5,000. Of those reporting medical debts, those debts accounted for only 13 percent of total unsecured debt. The DOJ summarizes the evidence against Himmelstein and colleagues' thesis as follows: "The conclusion that almost 50 percent of consumer bankruptcies are 'medical related' requires a broad definition and generally is not substantiated by the official documents filed by debtors."

Taking these surveys under consideration, we observe that although medical costs have risen sharply over four decades, medical debt remains a small part of the overall burden of those filing for bankruptcy.

Refining The Research Methods

The debate over Himmelstein and colleagues' numbers should not obscure a deeper methodological issue. It is insufficient to show that medical problems are associated with bankruptcy; one must also determine whether, and to what extent, medical spending causes bankruptcies. That is, one must move beyond correlation to causation and magnitude. In an attempt to do so, we have reanalyzed the data used by Himmelstein and colleagues.

The only portion of their paper that addresses causality is the first part of Exhibit 2, which identifies people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). If we seek to

learn the role of insurance in bankruptcies, we must identify those people who stated that illness or injury was a cause of bankruptcy and that medical bills contributed to bankruptcy. We call these "medical expenditure bankruptcies."

According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, we conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, we cannot state with any degree of certainty whether medical spending was the most important cause of bankruptcy. To move from causation to magnitude, one must perform multivariate statistical analysis on a sample of bankrupt and solvent individuals. The dependent variable would be a bankruptcy indicator. Predictors, in addition to those measured by Himmelstein and colleagues, would include economic and demographic variables such as employment and marital status. Only in this way could we make the kind of "all else equal" statements required to assess how medical debt affects bankruptcy rates. The authors fell well short of the mark. They neither interviewed a control population of solvent households nor collected economic control variables.

Several published studies of bankruptcy that did use multivariate analysis studies painted a different picture than the one depicted by Himmelstein and colleagues. We summarize key research below.

■ **Congressional Budget Office.** The Congressional Budget Office (CBO) analyzed the 75 percent increase in personal bankruptcy filings between 1994 and 1998 by reviewing the "voluminous" literature on personal bankruptcy in a 2000 report.[16] By all accounts, the period under review was one of flat to expanding health insurance coverage. The total health benefit cost per active employee rose less than 5 percent, and the cost of health benefits for active and retired workers actually declined in 1994 for the first time in memory.[17] The fact that bankruptcy rates nonetheless rose sharply suggests that something besides medical factors was to blame.

The CBO review cites many factors that contribute to bankruptcy, including large medical bills, divorce, loss of income as a result of unemployment, and poor debt management. Legislative changes making it easier for people to recover from bankruptcy may also have been a factor. Even so, the CBO reports that "researchers have made little progress in judging the *relative importance* of the factors that lead people to file" (emphasis added).

■ **Fay, Hurst, and White.** A 2002 study by Scott Fay, Erik Hurst, and Michelle White in *American Economic Review* is the only paper in an economics or finance journal to be cited by Himmelstein and colleagues, who refer only to an observation by Fay and colleagues about survey data.[18] A more thorough reading of the Fay paper, however, reveals several findings that are at odds with Himmelstein and colleagues' conclusions. Using data from a 1996 panel survey that included information about household bankruptcy filings, Fay and colleagues employed multivariate probit re-

gression to determine the contributing factors. Among those factors were whether the household head or spouse experienced health problems in the previous year. Controlling for debt levels, Fay and colleagues found no statistical link between bankruptcies and health problems. This finding is consistent with the idea that medical debt is like any other debt—a cause but not the most important cause of bankruptcy. They conclude that bankruptcy is the response to an accumulation of debt, not to one particular factor such as a health problem.

Data from the 2005 Commonwealth Fund biennial health survey support this conclusion. The survey found that 41 percent of adults ages 19–64 had a high rate of medical bill problems or incurred medical debt. Sixty-two percent of these nonelderly adults had insurance when the problem occurred. Yet although a sizable minority of these adults put off filling a prescription or going to the doctor, only one in ten of those who were insured all year said they had to "change [their] way of life to pay medical bills." Even for those who were uninsured for some period during the year, only 28 percent reported a lifestyle change.[19]

These two studies confirm the basic economic concept that all liabilities are fungible. No one category of liability is more likely than others to dictate a lifestyle change or even crossing over the brink into bankruptcy.

■ **Domowitz and Sartain.** A 1999 study by Ian Domowitz and Robert Sartain in the *Journal of Finance* examined 827 households who filed for bankruptcy in 1980 matched against 1,862 households not in bankruptcy.[20] Domowitz and Sartain performed multivariate nested logit regression to isolate the specific causes of bankruptcy. They first reported that "high medical debt (in excess of two percent of income) has the greatest single impact of any household condition variables in raising the conditional probability of bankruptcy." They tempered this finding with two further observations: First, only a tiny percentage of the population had high medical debt. Second, medical problems might be correlated with employment disruptions; if the latter contribute to bankruptcy, the coefficient on medical debt is biased upward. Accounting for prevalence of various sources of debt, Domowitz and Sartain found that "the largest single contribution to bankruptcy at the margin is credit card debt."

Other data on credit card payments support our previous contention that those with trouble paying all of their bills, not just medical expenses, are most vulnerable to bankruptcy. A recent Federal Reserve Board survey found an overall 1.1 percentage point decline from 1998 to 2001 in the proportion of debtors who were sixty or more days late with their payments on any of their loans in the preceding year, but an increase of 1.6 percentage points in late payment for families whose net worth was in the lowest 25 percent of the distribution.[21]

■ **Gross and Souleles.** A 2002 study by David Gross and Nicholas Souleles in the *Review of Financial Studies* is the first, to our knowledge, that uses a methodology that could directly determine the effect of insurance status on personal bankruptcy.[22] Gross and Souleles used multivariate regression to predict personal bank-

ruptcies, with one of their predictors being health insurance coverage. Although the study used individual-level bankruptcy data, its measure of insurance was at the state level. This leads to two potential biases. First, state-level insurance coverage is a "noisy" measure of each person's insurance status. This might reduce the measured impact of insurance. Second, interstate variation in insurance coverage might be correlated with unmeasured variation in the social safety net. This would increase the measured impact of insurance. Overall, it is difficult to draw firm conclusions from Gross and Souleles' analysis.

There is one methodological problem that occurs in all the papers cited above, including that of Himmelstein and colleagues. They all fail to address the problem of reverse causality—that is, whether medical spending causes bankruptcy or whether financial turmoil causes medical problems (for example, because of stress). The resulting endogeneity bias will therefore overstate the extent to which medical bills cause bankruptcy.

Policy Implications

The paper by Himmelstein and colleagues was intended to go beyond the generalization that personal bankruptcy represents a human tragedy and address specific questions: To what extent do high medical bills precipitate bankruptcy filings in the middle class, and to what extent is a Canadian-style health care system a likely solution? It is precisely in regard to these policy issues that the paper too often leaves fact behind and creates unrealistic myth.

The authors suggest the "low rate of medical bankruptcy in Canada" is to the credit of its health care system. The only source given for the rate is a *Texas Law Review* article attributing 7.1–14.3 percent of Canadian bankruptcies to "health/misfortune."[23] More broadly, their support for a Canadian model assumes a robust link between medical costs and bankruptcy that numerous econometric studies show is unjustified. Indeed, research specifically analyzing soaring bankruptcy rates in both countries attributed the increased filings primarily to easier access to credit through "financial liberalization."[24]

The role of easy credit was explicitly acknowledged by one of Himmelstein's coauthors (Elizabeth Warren) in a 2000 interview: "Today families are carrying so much more consumer debt that even a modest medical bill can put them over the edge financially."[25] Given that reality, the press-release prescription from Physicians for a National Health Plan, a group cofounded by Himmelstein and his coauthor Steffie Woolhandler, is difficult to justify. It says the Himmelstein and colleagues paper shows that "only national health insurance can solve the problem."

In their *Health Affairs* paper, Himmelstein and colleagues acknowledged that the impact of national health insurance would hinge on its being "much more comprehensive than many current policies." They do not delve into detail, but a 2004 study of women's expenses after being diagnosed with breast cancer illustrates just how comprehensive this national coverage would have to be. The study found

that mean monthly direct medical costs of insured women undergoing cancer therapy were $597, or 41 percent of the $1,455 monthly total costs of the disease.[26] This includes $134 for miscellaneous expenses (such as speech therapy) and "supplies" (such as lotions and laxatives). Direct nonmedical costs were $131 (for child care and the like), while indirect costs were $727, including time lost from work by the patient and family members. In other words, miscellaneous medical and nonmedical costs accounted for two-thirds of the monthly financial burden of this one cancer. To limit that economic impact, national health insurance would have to be far more comprehensive than any current single-payer system is.

Himmelstein and colleagues omit any reference to personal choices, such as taking on debt, even in their household interviews. In this they act more like good doctors than good economists or policymakers. For although it is good medical practice to work as hard to save the life of a careless drunk driver as a sober careful one, it is equally good economics and public policy to penalize the careless driver with higher insurance rates and possible criminal prosecution.

Finally, any form of national health insurance must be paid for. As economist Victor Fuchs points out, that process creates winners and losers whose identity might not be obvious. He writes:

> The ultimate cost falls on families and individuals, even when the payment mechanism makes it appear the bill is being sent elsewhere.... No magic wand of finance can divert labor, capital and other resources to medical care without resulting in a reduction in resources available for food, housing, education, recreation, or other goods and services.... The average family will have to pay the same share under any system.[27]

Put differently, weaving a medical-cost safety net that could protect virtually every person from bad behavior or bad luck might actually poke holes in the safety net for other vulnerable citizens. Good intentions are not enough. The Book of Job, far older than the Roman laws cited by Himmelstein and colleagues, teaches the hard lesson that no amount of good fortune is irreversible. Some combination of illness, job loss, and personal problems can assuredly dislodge even the most firmly rooted member of the middle class.

Unfortunately, expansive proposals to protect all of us distract from the pressing need to protect some of us, such as the forty-five million Americans with no health insurance and millions of others who are underinsured and vulnerable. "First, do no harm" is not just good advice for physicians; it should apply to those who would make health policy as well.

The authors are grateful to America's Health Insurance Plans for supporting this research.

NOTES

1. D U. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* 24 (2005): w63–w73 (published online 2 February 2005; 10.1377/hlthaff.w5.63).
2. See the California Healthline summary of news coverage and the Commonwealth Fund Issue Brief of August 2005 summary of research, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=108808 (accessed 26 August 2005). Reacting to the work of Himmelstein and colleagues, Sen.

Charles Grassley (R-IA) requested an analysis of the relationship between medical debt and bankruptcy from the Justice Department's Executive Office for United States Trustees.

3. *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, *Health Care Costs Survey*, 1 September 2005, http://www.kff.org/newsmedia/7371.cfm (accessed 22 February 2006).
4. S. Fay, E. Hurst, and M. White, "The Household Bankruptcy Decision," *American Economic Review* 92, no. 3 (2002): 706–718.
5. C.E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 35.
6. L. Mishel, M. Ettlinger, and E. Gould, "Less Cash in Their Pockets: Trends in Incomes, Wages, Taxes, and Health Spending of Middle-Income Families, 2000–03," 21 October 2004, http://www.epinet.org/content.cfm/bp154 (accessed 14 February 2006).
7. B. Stuart et al., "Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending under the Standard Medicare Drug Benefit," *Health Affairs* 24, no. 4 (2005): 1022–1031.
8. Employment Policy Foundation, "Employer Health Insurance Costs Continue to Rise," Fact Sheet (Washington: EPF, 3 August 2004).
9. EPF, "Rising Benefit Costs Crowd Out Wage Growth," Fact Sheet (Washington: EPF, 31 March 2005).
10. EPF, "Employer Health Insurance Costs."
11. PricewaterhouseCoopers Health Care Research Institute, "Rising Healthcare Costs Cut into Profits for Half of Large U.S. Businesses," 18 July 2005, http://www.barometersurveys.com/production/barsurv.nsf/vwallnewsbydocid/AB28E561F128EE9185257042004A29C4 (accessed 26 August 2005).
12. G. Heriot, "Misdiagnosed: A Medical-Bankruptcy Study Doesn't Live Up to Its Billing," *National Review Online*, 11 February 2005, http://www.nationalreview.com/script/printpage.p?ref=/comment/heriot200502110735.asp (accessed 26 August 2005). The *Health Affairs* eLetters are available online at http://content.healthaffairs.org/cgi/eletters/hlthaff.w5.63v1 (accessed 26 August 2005).
13. L. Conwell and J. Cohen, "Characteristics of Persons with High Medical Expenditures, 2002," Statistical Brief no. 73 (Rockville, Md.: Agency for Healthcare Research and Quality, March 2005).
14. L. Sittner et al., "Medical Expense as a Factor in Bankruptcy," *Nebraska State Medical Journal* 52, no. 9 (1967): 412–417.
15. H.F. Daly III et al., "Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured," *Health Matrix* 12, no. 1 (2002): 39–61.
16. Congressional Budget Office, *Personal Bankruptcy: A Literature Review* (Washington: U.S. Congress, 2000).
17. Mercer Human Resource Consulting, "U.S. Health Benefit Cost Rises 7.5 Percent in 2005, Lowest Increase in Five Years," Press Release, 22 November 2004, http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1162645 (accessed 26 August 2005).
18. Fay et al., "The Household Bankruptcy Decision."
19. M.M. Doty, J.N. Edwards, and A.L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," Issue Brief (New York: Commonwealth Fund, August 2005).
20. I. Domowitz and R. Sartain, "Determinants of Consumer Bankruptcy Decision," *Journal of Finance* 54, no. 1 (1999): 403–420.
21. A.M. Aizcorbe, A.B. Kennickell, and K.B. Moore, "Recent Changes in U.S. Family Finances: Evidence from the 1998 and 2001 Survey of Consumer Finances," *Federal Reserve Bulletin*, January 2003, http://www.federalreserve.gov/pubs/oss/oss2/2001/bull0103.pdf (accessed 26 August 2005).
22. D. Gross and N. Souleles, "An Empirical Analysis of Personal Bankruptcy and Delinquency," *Review of Financial Studies* 15, no. 1(2002): 319–347.
23. J.S. Ziegel, "A Canadian Perspective," *Texas Law Review* 79, no. 5 (2001): 241–256.
24. I. Livshits, J. MacGee, and M. Tertilt, "Accounting for the Rise in Consumer Bankruptcies in Canada and the United States," 9 March 2005, http://dept.econ.yorku.ca/seminars/2004-2005/BankruptcyRise.pdf (accessed 14 February 2006).
25. A.B. Crenshaw, "Study Cites Medical Bills for Many Bankruptcies," *Washington Post*, 25 April 2000.
26. A.M. Arozullah et al., "The Financial Burden of Cancer: Estimates from a Study of Insured Women with Breast Cancer," *Journal of Supportive Oncology* 2, no. 3 (2004): 271–278.
27. V. Fuchs, *Who Shall Live? Health, Economics and Social Choice* (New York: Basic Books, 1993), 127–128.

COMMENTARY

Who Really Pays for Health Care?
The Myth of "Shared Responsibility"

Ezekiel J. Emanuel, MD, PhD
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WHEN ASKED WHO PAYS FOR HEALTH CARE IN THE United States, the usual answer is "employers, government, and individuals." Most Americans believe that employers pay the bulk of workers' premiums and that governments pay for Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other programs.

However, this is incorrect. Employers do not bear the cost of employment-based insurance; workers and households pay for health insurance through lower wages and higher prices. Moreover, government has no source of funds other than taxes or borrowing to pay for health care.

Failure to understand that individuals and households actually foot the entire health care bill perpetuates the idea that people can get great health benefits paid for by someone else. It leads to perverse and counterproductive ideas regarding health care reform.

The Myth of Shared Responsibility

Many sources contribute to the misperception that employers and government bear significant shares of health care costs. For example, a report of the Centers for Medicare & Medicaid Services states that "the financial burden of health care costs resides with businesses, households, and governments that pay insurance premiums, out-of-pocket costs, or finance health care through dedicated taxes or general revenues."[1] A New America Foundation report claims, "There is growing bipartisan support for a health system based on shared responsibility—with the individual, employers, and government all doing their fair share."[2]

The notion of shared responsibility serves many interests. "Responsibility" is a popular catchword for those who believe everyone should pull their own weight, while "sharing" appeals to those who believe everyone should contribute to meeting common social goals. Politicians welcome the opportunity to boast that they are "giving" the people health benefits. Employers and union leaders alike want workers to believe that the employer is "giving" them health insurance. For example, Steve Burd, president and chief executive officer of Safeway, argued that decreasing health care costs is critical to his company's bottom line—as if costs come out of profits.[3] A highly touted alliance between Wal-Mart and the Service Employees International Union for universal coverage pledged that "businesses, governments, and individuals all [must] contribute to managing and financing a new American health care system."[4]

The Massachusetts health care reform plan is constructed around "shared responsibility." The rhetoric of health reform proposals offered by several presidential candidates helps propagate this idea. Hillary Clinton, for instance, claims that her American Health Choices plan "is based on the principle of shared responsibility. This plan ensures that all who benefit from the system contribute to its financing and management."[5] It then lists how insurance and drug companies, individuals, clinicians, employers, and government must each contribute to the provision of improved health care.

With prominent politicians, business leaders, and experts supporting shared responsibility, it is hardly surprising that most Americans believe that employers really bear most of the cost of health insurance.

The Health Care Cost–Wage Trade-off

Shared responsibility is a myth. While employers do provide health insurance for the majority of Americans, that does not mean that they are paying the cost. Wages, health insurance, and other fringe benefits are simply components of overall worker compensation. When employers provide health insurance to their workers, they may define the benefits, select the health plan to manage the benefits, and collect the funds to pay the health plan, but they do not bear the ultimate cost. Employers' contribution to the health insurance premium is really workers' compensation in another form.

This is not a point merely of economic theory but of historical fact. Consider changes in health insurance premiums, wages, and corporate profits over the last 30 years. Premiums have increased by about 300% after adjustment for inflation. Corporate profits per employee have flourished, with inflation-adjusted increases of 150% before taxes and 200% after taxes. By contrast, average hourly earnings of workers

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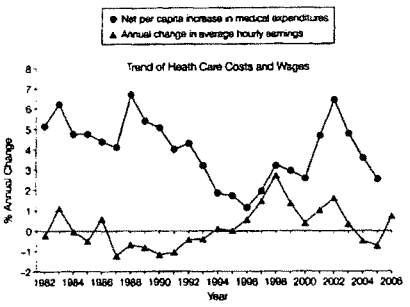
Figure. Changes in Per Capita Health Expenditures and Average Hourly Earnings (Adjusted for Inflation), 1982-2005



Data are from the Council of Economic Advisers[4] and Catlin et al.[7]

in private nonagricultural industries have been stagnant, actually decreasing by 4% after adjustment for inflation. Rather than coming out of corporate profits, the increasing cost of health care has resulted in relatively flat real wages for 30 years. That is the health care cost–wage trade-off.[6]

Even over shorter periods, workers' average hourly earnings fluctuate with changes in health care expenditures (adjusted for inflation) (FIGURE). During periods when the real annual increases in health care costs are significant, as between 1987 and 1992 and again between 2001 and 2004, inflation-adjusted hourly earnings are flat or even declining in real value. For a variety of reasons, the decline in wages may lag a few years behind health care cost increases. Insurance premiums increase after costs increase. Employers may be in binding multiyear wage contracts that restrict their ability to change wages immediately. Conversely, when increases in health care costs are moderate, as between 1994 and 1999, increases in productivity and other factors translate into higher wages rather than health care premiums.

The health care cost–wage trade-off is confirmed by many economic studies.[8-11] State mandates for inclusion of certain health benefits in insurance packages resulted in essentially all the cost of the added services being borne by workers in terms of lower wages.[12] Similarly, using the Consumer Expenditure Survey, Miller[13] found that "the amount of earnings a worker must give up for gaining health insurance is roughly equal to the amount an employer must pay for such coverage." Baicker and Chandra[14] reported that a 10% increase in state health insurance premiums generated a 2.3% decline in wages, "so that [workers] bear the full cost of the premium increase." Importantly, several studies show that when workers lose employer-provided health insurance, they actually receive pay increases equivalent to the insurance premium.[9,12]

In a review of studies on the link between higher health care costs and wages, Gruber[15] concluded, "The results [of studies] that attempt to control for worker selection, firm selection, or (ideally) both have produced a fairly uniform result: the costs of health insurance are fully shifted to wages."

The Cost–Public Service Trade-off

A large portion of health care coverage in the United States is provided by the government. But where does government's money for health care come from? Just as the ultimate cost of employer-provided health insurance falls to workers, the burden of government-provided health coverage falls on the average citizen. When government pays for increases in health care costs, it taxes current citizens, borrows from future taxpayers, or reduces other state services that benefit citizens: the health care cost–public service trade-off.

Health care costs are now the single largest part of state budgets, exceeding education. According to the National Governors Association, in 2006, health care expenditures accounted for an average of 32% of state budgets, while Medicaid alone accounted for 22% of spending.[16] Between 2000 and 2004, health care expenditures increased substantially, more than 34%, with Medicaid and SCHIP increasing more than 44%.[7] These increases far exceeded the increase in state tax receipts. In response, some states raised taxes, others changed eligibility requirements for Medicaid and other programs, and still others reduced the fees and payments to physicians, hospitals, and other providers of health care services.

However, according to a Rockefeller Institute of Government study of how 10 representative states responded, probably the most common policy change was to cut other state programs, and "the program area that was most affected by state budget difficulties in 2004 was public higher education . . . . On average, the sample states projected spending 4.5% less on higher education in FY 2004 than in FY 2003, and raised tuition and fees by almost 14% on average."[17] In other words, the increasing cost of Medicaid and other government health care programs are a primary reason for the substantial increase in tuition and fees for state colleges and universities. Middle-class families finding it more difficult to pay for their children's college are unwittingly falling victim to increasing state health care costs. Not an easy—but a necessary—connection to make.

Policy Implications

The widespread failure to acknowledge these effects of increasing health care costs on wages and on government services such as education has important policy implications. The myth of shared responsibility perpetuates the belief that workers are getting something while paying little or nothing. This undercuts the public's willingness to tax itself for the benefits it wants.

This myth of shared responsibility makes any reform that removes employers from health care much more difficult to enact. If workers and their families continue to believe that they can get a substantial fringe benefit like health insurance at no cost to themselves, they are less likely to consider alternatives. Unless this myth is dispelled, the centerpiece of reform is likely to be an employer mandate. This is regrettable and perpetuates the widely recognized historical mistake of tying health care coverage to employment. Furthermore, an employer mandate is an economically inefficient mechanism to finance health care. Keeping employers in health care, with their varied interests and competencies, impedes major changes necessary for insurance portability, cost control, efficient insurance exchanges, value-based coverage, delivery system reform, and many other essential reforms.[18,19] Employers should be removed from health care except for enacting wellness programs that directly help maintain productivity and reduce absenteeism. Politicians' rhetoric about shared responsibility reinforces rather than rejects this misconception and inhibits rather than facilitates true health care reform.

Not only does third-party payment attenuate the incentive to compare costs and value, but the notion that someone else is paying for the insurance further reduces the incentive for cost control. Getting Americans invested in cost control will require that they realize they pay the price, not just for the deductibles and co-payments, but for the full insurance premiums too.

Sustainable increases in wages require less explosive growth in health care costs. Only then will increases in productivity show up in higher wages and lower prices, giving a boost to real incomes. Similarly, the only way for states to provide more support for education, environment, and infrastructure is for health care costs to be restrained. Unless the growth in Medicaid and SCHIP are limited to—or close to—revenue increases, they will continue to siphon money that could be spent elsewhere.

Conclusion

Discussions of health care financing in the United States are distorted by the widely embraced myth of shared responsibility. The common claim that employers, government, and households all pay for health care is false. Employers do not share fiscal responsibility and employers do not pay for health care—they pass it on in the form of lower wages or higher prices. It is essential for Americans to understand that while it looks like they can have a free lunch—having someone else pay for their health insurance—they cannot. The money comes from their own pockets. Understanding this is essential for any sustainable health care reform.

Financial Disclosures: None reported.
Funding/Support: This research was supported by the Blue Shield Foundation of California, the Robert Wood Johnson Foundation, and the Department of Bioethics at the National Institutes of Health.
Role of the Sponsors: The funders had no role in the preparation, review, or approval of the manuscript.
Disclaimer: The opinions expressed are the authors' own. They do not represent any position or policy of the National Institutes of Health, Public Health Service, or Department of Health and Human Services.
Additional Contributions: Colleen Denny, BS, Brigette Madrian, PhD, and Rossannah Reeves assisted with data and analyses. No financial compensation was received.

REFERENCES

1. Centers for Medicare & Medicaid Services. Health expenditures by sponsors business, household and government. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg08.pdf. Accessed February 6, 2008.
2. Gallagher C, Harbage P. *Growing Support for Shared and Personal Responsibility in Health Care*. Washington, DC: New America Foundation; June 2007. http://www.newamerica.net/publications/policy/growing_support_shared_and_personal_responsibility_health_care. Accessed February 6, 2008.
3. Burd S. Meeting the US health care challenge. US Chamber of Commerce CEO Leadership Series: event summary. September 7, 2006. http://www.uschamber.com/NR/rdonlyres/ekv73cduc6ygrheayctrps464scvl7isnos4gi3zpp4vadkukz7ycircw3mwiey5qvh5nlsfeq3pgtj7nns7xnslhg/CEOSeriesSafeway.pdf. Accessed February 6, 2008.
4. Kavilanz PB. Wal-Mart, union push universal health care. February 7, 2007. http://money.cnn.com/2007/02/07/news/companies/walmart_healthcare/index.htm. Accessed February 6, 2008.
5. Hillary Clinton for President. American Health Choices plan. http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf. Accessed February 6, 2008.
6. Council of Economic Advisers. *Economic Report of the President*. Washington, DC: US Government Printing Office; February 2007. Appendix B, tables 3, 47, and 90. http://www.whitehouse.gov/cea/pubs.html. Accessed February 6, 2008.
7. Catlin A, Cowan C, Hartman M, et al. National health spending in 2006: a year of change for prescription drugs. *Health Aff (Millwood)*. 2008;27(1):14-29.
8. Eberts R, Stone J. Wages, fringe benefits, and working conditions: an analysis of compensating differentials. *South Econ J*. 1985;52:274-280.
9. Shemer L. *Health Care Costs, Wages, and Aging*. Washington, DC: Federal Reserve Board of Governors; April 1999. http://www.federalreserve.gov/pubs/feds/1999/199919/199919pap.pdf. Accessed February 6, 2008.
10. Royalty AB. *A Discrete Choice Approach to Estimating Workers' Marginal Valuation of Fringe Benefits*. Indianapolis: Indiana University–Purdue University; June 2003. http://liberalarts.iupui.edu/~anroyalt/wfdissch_j03.pdf. Accessed February 6, 2008.
11. Madrian BC. *The US Health Care System and Labor Markets*. Cambridge, MA: National Bureau of Economic Research; January 2006. NBER Working Paper No 11980. http://www.nber.org/papers/w11980. Accessed February 6, 2008.
12. Gruber J. The incidence of mandated maternity benefits. *Am Econ Rev*. 1994;84(3):622-641.
13. Miller RD. Estimating the compensating differential for employer-provided health insurance. *Int J Health Care Finance Econ*. 2004;4(1):27-41.
14. Baicker K, Chandra A. *The Labor Market Effects of Rising Health Insurance Premiums*. Cambridge, MA: National Bureau of Economic Research; February 2005. NBER Working Paper No. 11160. http://www.nber.org/papers/w11160. Accessed February 6, 2008.
15. Gruber J. Health insurance and the labor market. In: Culyer AJ, Newhouse JP, eds. *Handbook of Health Economics*. Vol 1. New York, NY: Elsevier Science; 2000.
16. *The Fiscal Survey of States*. Washington, DC: National Governors Association and National Association of State Budget Officers; June 2007. http://www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf. Accessed February 6, 2008.
17. Fossett JW, Burke CE. *Medicaid and State Budgets in FY 2004: Why Medicaid Is so Hard to Cut*. Albany, NY: Rockefeller Institute of Government; 2004. http://www.nysl.nysed.gov/scandoclinks/ocm56501455.htm. Accessed February 6, 2008.
18. Blumenthal D. Employer-sponsored health insurance in the United States—origins and implications. *N Engl J Med*. 2006;355(1):82-88.
19. Galvin RS, Delbanco S. Between a rock and a hard place: understanding the employer mind-set. *Health Aff (Millwood)*. 2006;25(6):1548-1556.

FTC Facts
For Consumers

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FEDERAL TRADE COMMISSION
FOR THE CONSUMER

www.ftc.gov ■ 1-877-ftc-help

November 2006

Before You File for Personal Bankruptcy:

Information About Credit Counseling and Debtor Education

Produced in cooperation with the Department of Justice's U.S. Trustee Program

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 launched a new era: With limited exceptions, people who plan to file for bankruptcy protection must get credit counseling from a government-approved organization within 180 days *before* they file. They also must complete a debtor education course to have their debts discharged.

The Department of Justice's U.S. Trustee Program approves organizations to provide the mandatory credit counseling and debtor education. Only the counselors and educatots that appear on the U.S. Trustee Program's lists can advertise that they are, indeed, approved to provide the required counseling and debtor education. By law, the U.S. Trustee Program does not operate in Alabama and North Carolina; in these states, court officials called Bankruptcy Administrators approve pre-bankruptcy credit counseling organizations and pre-discharge debtor education course providers.

COUNSELING AND EDUCATION REQUIREMENTS

As a rule, pre-bankruptcy credit counseling and pre-discharge debtor education may not be provided at the same time. Credit counseling must take place *before* you file for bankruptcy; debtor education must take place *after* you file.

In general, you must file a certificate of credit counseling completion when you file for bankruptcy, and evidence of completion of debtor education after you file for bankruptcy – but before your debts are discharged. Only credit counseling organizations and debtor education course providers that have been approved by the U.S. Trustee Program may issue these certificates. To protect against fraud, the certificates are produced through a central automated system and are numbered.

Pre-Bankruptcy Counseling

A pre-bankruptcy counseling session with an approved credit counseling organization should include an evaluation of your personal financial situation, a discussion of alternatives to bankruptcy, and a personal budger plan. A typical counseling session should last about 60 to 90 minutes, and can take place in person, on the phone, or online. The counseling organization is required to provide the counseling free of charge for those consumers who cannot afford to pay. If you cannot afford to pay a fee for credit counseling, you should request a fee waiver from the counseling organizarion before the session begins. Otherwise, you may be charged a fee for the counseling, which will generally be about $50, depending on where you live, the types of services you receive, and other factors. The counseling organization is required to discuss any fees with you before starting the counseling session.

Once you have completed the required counseling, you must get a certificate as proof.

Once you have completed the required counseling, you must get a certificate as proof. Check the U.S. Trustee's website to be sure that you receive the certificate from a counseling organization that is approved in the judicial district where you are filing bankruptcy. Credit counseling organizations may not charge an extra fee for the certificate.

Post-Filing Debtor Education

A debtor education course by an approved provider should include information on developing a budget, managing money, using credit wisely, and other resources. Like pre-filing counseling, debtor education may be provided in person, on the phone, or online. The debtor education session might last longer than the pre-filing counseling – about two hours – and the typical fee is between $50 and $100. As with pre-filing counseling, if you are unable to pay the session fee, you should seek a fee waiver from the debtor education provider. Check the list of approved debtor education providers at **www.usdoj.gov/ust/eo/bapcpa/ccde/de_approved.htm** or at the bankruptcy clerk's office in your district.

Once you have completed the required debtor education course, you should receive a certificate as proof. This certificate is separate from the certificate you received after completing your pre-filing credit counseling. Check the U.S. Trustee's website to be sure that you receive the certificate from a debtor education provider that is approved in the judicial district where you filed bankruptcy. Unless they have disclosed a charge to you before the counseling session begins, debtor education providers may not charge an extra fee for the certificate.

Important Questions to Ask When Choosing a Credit Counselor

It's wise to do some research when choosing a credit counseling organization. If you are in search of credit counseling to fulfill the bankruptcy law requirements, make sure you receive services only from approved providers for your judicial district.

Check the list at **www.usdoj.gov/ust/eo/bapcpa/ccde/cc_approved.htm** or at the bankruptcy clerk's office for the district where you will file. Once you have the list of approved organizations in your judicial district, call several to gather information before you make your choice. Some key questions to ask are:

- What services do you offer?
- Will you help me develop a plan for avoiding problems in the future?
- What are your fees?
- What if I can't afford to pay your fees?
- What qualifications do your counselors have? Are they accredited or certified by an outside organization? What training do they receive?
- What do you do ro keep information about me (including my address, phone number, and financial information) confidential and secure?
- How are your employees paid? Are they paid more if I sign up for certain services, if I pay a fee, or if I make a conrribution to your organization?

For More Information and Assistance

The U.S. Trustee Program promotes integrity and efficiency in the nation's bankruptcy system by enforcing bankruptcy laws, providing oversight of private trustees, and maintaining operational excellence. The Program has 21 regions and 95 field offices, and oversees the administration of bankruptcy in all states except Alabama and North Carolina. For more information, visit **www.usdoj.gov/ust**.

If you have concerns about approved credit counseling agencies or debtor education course providers, such as the failure to provide adequate service, please contact the U.S. Trustee Program by email at **USTCCDEComplaintHelp@usdoj.gov**, or in writing at Executive Office for U.S. Trustees, Credit Counseling and Debtor Education Unit, 20 Massachusetts Avenue, N.W., Suite 8000, Washington, D.C., 20530. Provide as much detail as you can, including the name of the credit counseling organization or debtor education course provider, the date of contact, and whom you spoke with.

The Federal Trade Commission works for the consumer to prevent fraudulent, deceptive and unfair business practices in the marketplace and to provide information to help consumers spot, stop, and avoid them. For more information about credit issues and choosing a credit counselor, visit **ftc.gov/credit**. To file a complaint or ro get free information on consumer issues, visit **ftc.gov** or call toll-free 1-877-FTC-HELP (1-877-382-4357); TTY: 1-866-653-4261. If a credit counseling organization falsely advertises it is approved by the U.S. Trustee, please report this to the FTC via the toll-free number.

4 FTC Facts For Consumers

The Federal Trade Commission (FTC) is the nation's consumer protection agency. Here are some tips from the FTC to help you be a more savvy consumer.

- Know who you're dealing with. Do business only with companies that clearly provide their name, street address, and phone number.
- Protect your personal information. Share credit card or other personal information only when buying from a company you know and trust.
- Take your time. Resist the urge to "act now." Most any offer that's good today will be good tomorrow, too.
- Rate the risks. Every potentially high-profit investment is a high-risk investment. That means you could lose your investment - all of it.
- Read the small print. Get all promises in writing and read all paperwork before making any payments or signing any contracts. Pay special attention to the small print.
- "Free" means free. Throw out any offer that says you have to pay to get a gift or a "free" gift. If something is free or a gift, you don't have to pay for it. Period.
- Report fraud. If you think you've been a victim of fraud, report it. It's one way to get even with a scam artist who cheated you. By reporting your complaint to 1-877-FTC-HELP or www.ftc.gov, you are providing important information to help law enforcement officials track down scam artists and stop them!

Federal Trade Commission
Bureau of Consumer Protection
Division of Consumer and Business Education

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Fraser Alert
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35
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July 2009

Health Insurance and Bankruptcy Rates in Canada and the United States

Main Conclusions

- Unlike the United States, Canada has a universal, single-payer, government-run, socialized health insurance system.
- Advocates of socialized medicine argue that the mixed public-private health insurance system in the United States causes many Americans to become financially bankrupt, and that this would not occur if the US adopted the Canadian health system.
- Following this logic, we should expect to observe a lower rate of personal bankruptcy in Canada than in the United States.
- Yet the most recent data (2006 and 2007) shows that personal bankruptcy rates are actually higher in Canada (.30% for both years) than in the United States (.20% and .27%).
- Research indicates that medical spending was only one of several contributing factors in 17 percent of US bankruptcies, and that medical debts accounted for only 12 to 13 percent of the total debts among American bankruptcy filers who cited medical debt as one of their reasons for bankruptcy.
- Research also indicates that medical reasons were cited as the primary cause of bankruptcy by approximately 15 percent of bankrupt Canadian seniors (55 years of age and older).
- The US-Canada comparative analysis strongly suggests that bankruptcy statistics do not support arguments for a government-run health insurance system.

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Table 1: Consumer (non-business) Bankruptcies Filed in Canada and the United States, 2006 and 2007

	2006		2007	
	Canada	**USA**	**Canada**	**USA**
Total Consumer Bankruptcy Filings	98,400	597,965	99,282	822,590
Total Population	32,576,100	298,754,819	32,927,400	301,621,157
Consumer Bankruptcy Filings as a Percentage of Population	0.30%	0.20%	0.30%	0.27%

Notes: Table includes total non-business bankruptcy filings only in both countries. Canadian data include bankruptcy and consumer proposals, which are conceptually similar to American bankruptcy Chapters 7 and 13 respectively (Bankruptcy Canada, 2009a; 2009b).
Sources: Office of the Superintendent of Bankruptcies, Canada, 2006, 2007, 2008, 2009; US Courts, 2009; Statistics Canada, 2009a; US Census Bureau, 2009.

Introduction

In a recent update to a previous study, Himmelstein et al (2009) concluded that in 2007, uninsured medical expenses or loss of income due to illness "caused" (Himmelstein et al., 2009, "Table 2: Medical Causes of Bankruptcy, 2007," p. 3) nearly two-thirds (62.1 percent) of all non-business bankruptcies in the United States. The authors blame this on America's pluralistic health insurance system.[1] Himmelstein and co-author Woolhandler are well-known proponents of Canada's government-run, single-payer medical insurance system (e.g. Woolhandler et al., 2003; McCormick et al., 2004; Woolhandler and Himmelstein, 2004).[2] The implicit assumption of their study is that a single-payer system would have prevented or significantly reduced the number of bankruptcies observed in the United States. Following this logic, we should expect to observe a lower rate of bankruptcy in Canada compared to the United States, all else being equal. Yet the most recent data shows that the non-business bankruptcy rate in Canada is statistically the same as it is in the United States.

Data and analysis

Table 1 shows the number of consumer or personal bankruptcies, excluding business bankruptcies, in both countries for 2006 and 2007—the two most recent years for which we have data. All data are taken directly from government sources in both countries. All data are defined in conceptually similar ways for both countries. The data show that the total number of non-business bankruptcy filings represented less than one-third of one percent of the total population in both countries. There is no significant difference between the percentages. Where there is a difference, the data show that non-business bankruptcy rates are actually higher in Canada.

Aside from universal single-payer health insurance, there are few other significant health, social, or legal policy differences between the two countries that could be causally linked to bankruptcy rates. For example,

- The 2005 reforms to US bankruptcy laws have produced legal standards that are very similar to Canadian standards (BankruptcyCanada, 2009a; 2009b).
- Drug insurance is structured almost identically, so exposure to drug costs is similar in both countries. While the entire Canadian population is universally eligible for publicly funded insurance for hospital and physician services, only about one-third of the Canadian population is publicly insured for prescription drugs. In Canada, as in the US, low-income people, disabled populations, and seniors are eligible for separate publicly

funded drug programs, while most employed people obtain drug insurance as a benefit of employment, and the rest of the population pays with their own money.

- Both countries have employment insurance programs that provide income support in the event of job loss (US Department of Labor, 2004; Service Canada, 2009). Unemployment occurs with roughly similar frequency among Canadians and Americans. National unemployment rates in 2007 were 5.3 percent in Canada versus 4.6 percent in the United States (Statistics Canada, 2009b).
- Access to medical care for people who experience long-term unemployment, disability from illness, and chronic low-income status is practically the same in both countries, being facilitated by non-profit, publicly funded community health centers (NACHC, 2009) and public programs like Medicaid in the US, and government-run systems in Canada.

Medical bankruptcies in Canada

Medical reasons for bankruptcies are not unique to the US. Research commissioned by the Canadian government (Redish et al., 2006) indicates that medical reasons were cited as the primary cause of bankruptcy for approximately 15 percent of bankrupt Canadian seniors (55 years of age and older). Medical reasons included lost income or employment due to illness, as well as uninsured medical expenses.

Other research

These findings reinforce earlier criticisms of Himmelstein et al (2005). In particular, Dranove and Millenson (2006) reviewed the literature on medical bankruptcy and found that, "studies since the mid-1960s have consistently concluded that medical bills are a relatively minor part of the debt problem" (Dranove and Millenson, 2006: w78). Studies the two researchers reviewed, including one by the US Department of Justice, estimated that medical debts accounted for only between 12 and 13 percent of total unsecured debt among bankruptcy filers who cited medical debts as a contributing factor to their bankruptcy (Dranove and Millenson, 2006). More specifically, they examined the data and methodology in Himmelstein et al (2005) and concluded that the study

> fail[ed] to provide a causal relationship to support the claim that medical spending contributes to "half of all bankruptcies" (54.5 percent). Our analysis of their data finds a causal link in only 17 percent of personal bankruptcies... the authors' methodology does not provide a definitive answer to the policy question they implicitly pose: how national health insurance would affect the rate of personal bankruptcy. At best, they show that medical bills are a cause of 17 percent of bankruptcies but are not necessarily the most important cause. They fail to perform the multivariate statistical analysis necessary to determine the magnitude of the causal relationship or to rule out other factors such as loss of job, education expenses, or housing costs. (Dranove and Millenson, 2006: w75)

Conclusion

Canada's universal, government-run, monopoly health insurance system was not associated with lower rates of bankruptcy in Canada compared with the United States in either 2006 or 2007. It is incorrect to assume that adopting such an insurance system in the US will have a significant impact on bankruptcy rates. Bankruptcy and a lack of health insurance coverage are both caused by the same thing—a lack of income, which in turn is usually a result of unemployment. Illness can certainly cause unemployment, which can lead to bankruptcy if people have unsustainable debt loads. However, non-medical expenditures comprise the majority of debt among bankrupt consumers in both Canada and the US. The inability to earn sufficient income to cover these costs—not exposure to uninsured medical costs—is the real explanation for almost all bankruptcies in either country. The US-Canada comparative analysis strongly suggests that bankruptcy statistics do not support arguments for a government-run, single-payer, socialized health insurance system.

Notes

1 Himmelstein et al (2009) conclude that, "Medical impoverishment, although common in poor nations, is almost unheard of in wealthy

countries other than the US. Most provide a stronger safety net of disability income support. All have some form of national health insurance. The US health care financing system is broken, and not only for the poor and uninsured. Middle-class families frequently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones" (Himmelstein et al 2009: 5-6).

2 Himmelstein's and Woolhandler's advocacy of Canada's single-payer health insurance system is also reflected in several other studies, commentaries and opinion editorials.

References

BankruptcyCanada (2009a). Bankruptcy in America. Web page. http://www.bankruptcycanada.ca/bankruptcy/bankruptcy-america.htm, as of June 17, 2009.

BankruptcyCanada.com (2009b). Canadian vs. American Personal Bankruptcy—Which is Better? Bankruptcy Canada Blog. http://www.bankruptcycanada.com/blog/canadian-vs-us-bankruptcy/

Dranove, David, and Michael L. Millenson (2006, February 28). Medical Bankruptcy: Myth versus Fact. *Health Affairs*—Web Exclusive, 25(2006): w74-w83. DOI 10.1377/hlthaff.25.w74. http://content.healthaffairs.org/cgi/content/abstract/25/2/w74, published February 28, 2006.

Himmelstein, David U., Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler (2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *American Journal of Medicine*. http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf as of June 15, 2009.

Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler (2005). Illness and Injury as Contributors to Bankruptcy. *Health Affairs*—Web Exclusive. DOI 10.1377/hlthaff.W5.63. http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.pdf, as of June 15, 2009.

McCormick, Danny, David U. Himmelstein, Steffie Woolhandler, and David H. Bor (2004). Single-Payer National Health Insurance: Physicians' Views. *Archives of Internal Medicine*, 164(3): 300-304.

National Association of Community Health Centers [NACHC] (2009). *America's Health Centers*. Fact Sheet #0109 (March).

Office of the Superintendent of Bankruptcies, Canada (2006). *An Overview of Canadian Insolvency Statistics: Up to 2006*. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/vwapj/Statsbooklet2007-EN.pdf/$FILE/Statsbooklet2007-EN.pdf, as of June 12, 2009.

Office of the Superintendent of Bankruptcies, Canada (2007). *Annual Statistical Report, 2007*. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/vwapj/annual-report2007.pdf/$FILE/annual-report2007.pdf, as of June 12, 2009.

Office of the Superintendent of Bankruptcies, Canada (2008). Insolvency Statistics in Canada—2008. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/vwapj/Annual%20report%202008_eng.pdf/$FILE/Annual%20report%202008_eng.pdf, as of June 12, 2009.

Office of the Superintendent of Bankruptcies, Canada (2009). Annual Consumer Insolvency Rates by Province and

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ISSN 1714-6720

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Editing, design, and production

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Economic Region, 2000-2008. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/eng/br01820.html (date modified: 2009-05-21), as of June 12, 2009.

Redish, Angela, Janis Sarra, and Margaret Schabas (2006). Table 4: Primary Causes of Bankruptcy, Reported—By Age. *Growing Old Gracefully: An Investigation into the Growing Number of Bankrupt Canadians over age 55*. Office of the Superintendent of Bankruptcy. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/vwapj/Redish-Sarra_Schabas_2006-ENG.pdf/$FILE/Redish-Sarra_Schabas_2006-ENG.pdf, as of June 17, 2009. See also Chart 6: Causes of Bankruptcy—Reported Primary Cause. In *Growing Old Gracefully: An Investigation into the Growing Number of Bankrupt Canadians over age 55*, Part 6. http://www.ic.gc.ca/eic/site/bsf-osb.nsf/eng/br01686.html, as of June 17, 2009.

Service Canada (2009). Employment Insurance. Web page. http://www.servicecanada.gc.ca/eng/ei/ei/index.shtml (date modified: 2009-06-11), as of June 17, 2009.

Statistics Canada (2009a). Population by year, by province and territory. As of July 1. CANSIM, table (for fee) 051-0001. http://www40.statcan.ca/l01/cst01/demo02a-eng.htm (last modified: 2009-01-15), as of June 12, 2009.

Statistics Canada (2009b). Unemployment rates, Canada and the United States. Web page. http://www.statcan.gc.ca/pub/71-222-x/2008001/section/p-unemployment-chomage-eng.htm (date modified: 2008-11-25), as of June 16, 2009.

US Census Bureau (2009). Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007 (NST-EST2007-01). http://www.census.gov/popest/estimates.php (last modified: March 18, 2009), as of June 12, 2009.

US Courts (2009). Bankruptcy Statistics. Table F-2: U.S. Bankruptcy Courts, Business and Nonbusiness Bankruptcy Cases Commenced, by Chapter of the Bankruptcy Code, During the Twelve-Month Period Ended Dec. 31, 2006 and Dec. 31, 2007. http://www.uscourts.gov/bnkrpctystats/statistics.htm#calendar, as of June 12, 2009.

US Department of Labour (2004). State Unemployment Insurance Benefits. Web page. http://workforcesecurity.doleta.gov/unemploy/uitaxfact.asp (updated December 2, 2008), as of June 17, 2009.

Woolhandler, Steffie, and David U. Himmelstein (2004). The high costs of for-profit care. Commentary. *Canadian Medical Association Journal*, 170(12): 1814-1815.

Woolhandler, Steffie, Terry Campbell, and David U. Himmelstein (2003). Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine*, 349(8) (August 21): 768-775.

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Testimony on Medical Debt:
Can Bankruptcy Reform Facilitate a Fresh Start?

Diana Furchtgott-Roth
Senior Fellow, Hudson Institute

Testimony before the Senate Committee on the Judiciary,
Subcommittee on Administrative Oversight and the Courts

October 20, 2009

Testimony on Medical Debt:
Can Bankruptcy Reform Facilitate a Fresh Start?

Diana Furchtgott-Roth
Senior Fellow, Hudson Institute

Mr. Chairman, members of the Committee, I am honored to be invited to testify before your Committee today on the subject of medical debt and bankruptcy reform. I have followed and written about this and related issues for many years. Currently, I am a Senior Fellow at the Hudson Institute. From February 2003 until April 2005, I was Chief Economist at the U.S. Department of Labor. From 2001 until 2003, I served at the President's Council of Economic Advisers as Chief of Staff and Special Adviser. Previously, I was a Resident Fellow at the American Enterprise Institute. I also served as Deputy Executive Secretary of the Domestic Policy Council in the White House under President George H.W. Bush and as an economist on the staff of President Ronald Reagan's Council of Economic Advisers.

A recent study in the American Journal of Medicine conducted by Dr. David Himmelstein and other researchers from Harvard University and Ohio University found that medical debts are the major cause of personal bankruptcy in America.[1] The study found that 62 percent of bankruptcies in 2007 were "medical;" that medical debtors were not poor, but middle-class; and that the percent share of bankruptcies due to medical problems rose by 50 percent

[1] David H. Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine*, Vol. 122, No. 8, 741-746, 2009.

between 2001 and 2007. The Himmelstein study paints a picture of an American middle class that, even with health insurance coverage, is being bankrupted by health care costs. The message is that rising health care costs bankrupt the insured middle class as well as the uninsured lower class.

This study is being used to support the need for the major healthcare reform bills before the House and the Senate. On July 27, 2009, House Judiciary Chairman John Conyers of Michigan said, "This surge in medical bankruptcies demonstrates why health care reform is urgently needed right now. So many people's lives are uprooted, and their financial security destroyed, by unexpected medical costs."[2]

The only problem is that the study is fatally flawed. Dr. Himmelstein and his coauthors got different results because they used a smaller sample and a different methodology than other studies. They started with a random sample of 5,251 bankruptcy petitions and wound up through a series of screenings only using 1,032. Only 45 percent of those who completed questionnaires were interviewed by phone. The rest were unwilling to be interviewed, or could not be found. It is possible that the remaining 55 percent of the sample had no problem with medical costs, and that is why they were uninterested in participating. Of those interviewed, 62 percent were identified as having health

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[2] U.S. House Committee on Judiciary, "Conyers Dismayed by Rise in Medical Bankruptcies" (News Release), July 27, 2009. Available at: http://judiciary.house.gov/news/090727.html

problems that contributed to bankruptcy. This equaled 28 percent of those who completed questionnaires.

Furthermore, the authors did not properly distinguish reasons for bankruptcy. All those who were bankrupt and who had medical debt were considered to be bankrupt for medical reasons. In reality, other forms of debt could have been the true cause of bankruptcy. One definition of "medically bankrupt" was those who were bankrupt and who reported uncovered medical bills of greater than $1,000 in the past two years—or $500 per year. It is not unusual for families have expenses of $500 per year that are not covered by insurance, when dental bills, copayments, and prescriptions are totaled. Another definition of "medically bankrupt" was those who were bankrupt and "who lost at least 2 weeks of work-related income due to illness or injury." Again, this is not that uncommon. A salesman on commission who comes down with the flu, or a cold, could lose 2 weeks of work-related income in a year. He could not have any medical debts at all and still be classified as "medically bankrupt" according to the study's methodology. Hypothetically, someone could go into bankruptcy while on Medicare or Medicaid, even if they owed no medical bills at all.

Most important, Dr. Himmelstein's study contradicts the standard economics literature on personal bankruptcies. Most reputable studies are based on the Survey of Consumer Finances, published by the Federal Reserve, which

lists different types of consumer debt[3]. Debt from goods and services, which includes medical debt, rose slightly from 5.5 percent of all debt in 2001 to 5.8 percent of all debt in 2007. Fewer than one percent of Americans enter bankruptcy each year. Of those, only three to five percent are plausibly bankrupt due to medical debt. These data and studies present the inconvenient truth that our health system is not leading to bankruptcy in America. Our healthcare system needs reform, but not of the type currently under consideration by Congress.

Economic studies that contradict Dr. Himmelstein have been authored by American Enterprise Institute research fellow Aparna Mathur[4]; Northwestern University economics professors David Dranove and Michael Millenson[5]; economics professors Scott Fay, Erik Hurst, and Michelle White from University of Florida, University of Chicago, and University of California, San Diego respectively[6]; and economist David Gross from Compass Lexecon and economics professor Nicholas Souleles from the University of Pennsylvania[7].

Why does Dr. Himmelstein get such different results? One reason could be that he is a co-founder of Physicians for a National Health Program, an

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[3] The Federal Reserve Board, "Survey of Consumer Finances," 2007. Available at: http://www.federalreserve.gov/pubs/oss/oss2/sctindex.html

[4] Aparna Mathur, "Medical Bills and Bankruptcy Filings". American Enterprise Institute, 2006. Available at: http://www.aei.org/docLib/20060719_MedicalBillsAndBankruptcy.pdf

[5] David Dranove and Michael L. Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affaris, 25(2), w74-w83, 2006.

[6] Scott Fay et al. "The Household Bankruptcy Decision," *The American Economic Review*, 92(3), 706-718, 2002.

[7] David Gross and Nicholas Souleles, "An Empirical Analysis of Personal Bankruptcy and Delinquency," *Review of Financial Studies*, 15(1), 319-347, 2002.

organization that describes itself on its Web site as "the only national physician organization in the United States dedicated exclusively to implementing a single-payer national health program."[8] An additional Harvard coauthor, Dr. Steffie Woolhandler, is co-founder and secretary of the organization. Even though their article states on the front page that the authors have no conflict of interest, two are self-declared activists for single-payer health care, and they have twisted the data to fit their cause.

Even using Dr. Himmelstein's methodology, single-payer health care would not solve the medical bankruptcy problem. People would still lose work time to illness, perhaps even more time than under the current system, because health care would be of lower quality. Our healthcare system needs reform, but not of the type currently under consideration by Congress, which includes consideration of a national health care plan.

Although the leading Democratic healthcare reform bills in Congress—the Senate HELP Committee's Affordable Health Choices Act[9], the Senate Finance Committee's America's Healthy Future Act of 2009[10], and the House Education

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[8] Physicians for a National Health Program, "About PNHP". Available at: http://www.pnhp.org/about/about_pnhp.php

[9] U.S. Senate "Affordable Health Choices Act". 111th Congress, 1st session. S. 1679. Washighton: GPO, September 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1679pcs.txt.pdf

[10] U.S. Senate Committee on Finance, "America's Healthy Future Act of 2009". Available at: http://www.finance.senate.gov/sitepages/leg/LEG percent202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf

and Labor Committee's America's Affordable Health Choices Act of 2009[11]—are well-intended, they would leave all Americans worse off than they are at present, and actually increase the probability of bankruptcy by lowering income available for discretionary spending. First, the vast majority would pay more for health insurance. Second, the higher cost of health insurance premiums would lower cash wages for Americans. Third, those on government plans, such as Medicare and Medicaid, would receive worse care. Fourth, the economy-wide effects of health care reform mandates would discourage job creation and incentives to work by raising taxes.

Everyone would pay more for health insurance, contributing to bankruptcies. Young people and those in good health would have to pay substantially more for health insurance than they do at present because premium differentials for health insurance would be capped. Almost everyone would have to pay more due to the government's definition of a qualified plan.

One feature of the health reform bills is that variation in premiums would be limited. Under the House Democrats' bill, for example, the most expensive premium could not be more than twice as much as the cheapest for the same plan, and variation would only be allowed on the basis of age. This means that young people would have to pay far more in premiums than they would otherwise.

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[11] U.S. House "America's Affordable Health Choices Act of 2009". 111th Congress, 1st session. H.R. 3200. Washighton: GPO, July 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3200ih.txt.pdf

The Baucus bill would require everyone to purchase health insurance or face penalties. Americans with incomes up to 400 percent of the poverty line (currently $90,100 for a family of four) who are not covered by an employer plan would receive tax credits to purchase health insurance plans in an "exchange."

Plans purchased in the exchange would have generous coverage and no lifetime or annual limits on any benefits. Only Americans under 25 and those who spend more than eight percent of their income on health insurance premiums would be allowed to purchase "young invincible" plans, catastrophic insurance against major accidents. Americans would have to pay a far higher cost for health insurance, since plans would have to accept everyone, regardless of health or pre-existing conditions.

It is easy to see from the Baucus bill why the cost of health insurance is going to increase substantially. According to the Senate Finance Committee, "All plans would be required to provide primary care and first-dollar coverage for preventive services, emergency services , medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy, and mental health and substance abuse services.

Plans would not be allowed to set lifetime limits on coverage or annual limits on any benefits."[12]

Half of the expenses in the Baucus plan would be funded through an excise tax on expensive plans of 40 percent on premiums above $8,000 for singles and $21,000 for families, bringing in $201 billion from 2013 through 2019. Today health insurance premiums cost on average $4,824 for singles and $13,375 for families.[13] CBO calculates that in 2019, in addition to $46 billion in excise taxes, Americans would be paying over $100 billion in higher premiums.[14] Since CBO forecasts increases in excise tax revenues of 10 percent to 15 percent annually after 2019, health insurance premiums must also rise by the same percent annually. This government mandate would amount to a steady drain on American men and women. A memo dated October 13, 2009, from Thomas Barthold, chief of staff of the Joint Committee on Taxation, said "Generally, we expect the insurer to pass along the cost of the excise tax to consumers by increasing the price of health coverage."[15]

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[12] U.S. Senate Committee on Finance, "Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage" (News Release), September 16, 2009. Available at: http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf

[13] The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2009 Annual Survey" September 15, 2009. Available at: http://ehbs.kff.org/pdf/2009/7936.pdf

[14] Congressional Budget Office. "Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended", October 7, 2009. Available at: http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

[15] Joint Committee on Taxation. "Memo from Thomas A. Barthold to Cathy Koch and Mark Prater," October 13, 2009. http://www.hudson.org/files/documents/Response_Cathy_Koch_Mark_Prater_40-Percent_Excise_Tax_High_Coverage_Health_Plans.pdf.

The higher cost of health insurance premiums would lower cash wages for everyone, contributing to bankruptcies. A government mandate for employers to provide health insurance would cause wages to decline, because the costs of the insurance would be passed on to workers, who would see a decline in wages. Alternatively, as discussed in the following section, employers would reduce employment, especially for low-wage workers.

Harvard University economics professor Katherine Baicker and University of Michigan economics professor Helen Levy concluded that low-income, minority workers would be the most affected by a government mandate:[16] "We find that 33 percent of uninsured workers earn within $3 of the minimum wage, putting them at risk of unemployment if their employers were required to offer insurance. ... Workers who would lose their jobs are disproportionately likely to be high school dropouts, minority, and female. ... Thus, among the uninsured, those with the least education face the highest risk of losing their jobs under employer mandates."

Employers are likely to respond to the higher costs resulting from mandated provision of health insurance by employing fewer workers, or outsourcing jobs overseas. This would increase the probability of bankruptcy. Those employed by small businesses would be disproportionately affected, because many small businesses employ low-income wage workers at or near the

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[16] Katherine Baicker and Helen Levy, "Employer Health Insurance Mandates and the Risk of Unemployment," NBER Working Paper No. 13528, October 2007. Available at: http://www.nber.org/papers/w13528.pdf.

minimum wage, and cannot reduce these wages to absorb the increased cost. It is no coincidence that this summer's increase in the minimum wage to $7.25 per hour[17] was followed by record teen unemployment rates, the latest almost 26 percent in September[18]. Employers laid off the less-skilled workers rather than paying them more than they were worth.

The Congressional Budget Office concluded that a requirement for employers to provide health insurance would encourage employers to hire more part-time workers and fewer full-time workers. According to CBO, the creation of different penalties for full and part time workers "would increase incentives for firms to replace full-time employees with more part-time or temporary workers."[19]

According to Ezekiel Emanuel and Victor Fuchs in the *Journal of the American Medical Association*, "It is essential for Americans to understand that while it looks like they can have a free lunch—having someone else pay for health insurance—they cannot. The money comes from their own pockets. Understanding this is essential for any sustainable health care reform."[20] Peter

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[17] U.S. Department of Labor Wage and Hour Division, "Employee Rights under the Fair Labor Standards Act," July 2009. Available at: http://www.dol.gov/esa/whd/regs/compliance/posters/minwagep.pdf

[18] Bureau of Labor Statistics, "The Employment Situation - September 2009".

[19] Congressional Budget Office, "Effects of Changes to the Health Insurance System on Labor Markets," July 13, 2009. Available at: http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf

[20] Ezekiel J. Emanuel and Victor R. Fuchs, "Who Really Pays for Health Care Costs," *Journal of the American Medical Association*, March 5, 2008. Similarly, Harvard economist Katherine Baicker wrote, "Employees ultimately pay for the health insurance they get through their employer, no matter who writes the check to the insurance company. The view that we can get employers to shoulder the cost of providing health insurance stems from the misconception that employers

Orszag reiterated this as CBO director, saying that, "The economic evidence is overwhelming, the theory is overwhelming, that when your firm pays for your health insurance you actually pay through reduced take-home pay. The firm is not giving that to you for free. Your other wages or what have you are reduced as a result. I don't think most workers realize that."[21]

Those on government plans, such as Medicare and Medicaid, would receive worse care, losing more work time. Medicare recipients would receive a lower standard of care than they do at present due to cuts in the program. Putting more Americans into the Medicaid program would give them a lower standard of care.

Nearly 90 percent of the $404 billion Medicare and Medicaid savings would be from Medicare in the period 2013 to 2019 in the Baucus bill. Thereafter, savings would be expected to continue at the rate of 10 percent to 15 percent. CBO estimates that Medicare Advantage plans, popular bundled health maintenance organizations serving 20 percent of Medicare patients, would be cut by $117 billion.[22] Under the heading "Ensuring Medicare Sustainability," more than $200 billion would be cut from payments to hospitals, elder care, doctors, and hospices. Payments to Medicare doctors would be cut by 25 percent in 2011. A Medicare Commission would propose further cuts.

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pay for benefits out of a reservoir of profits. Regardless of a firm's profits, valued benefits are paid for primarily out of workers' wages." Katherine Baicker and Amitabh Chandra, "Myths and Misconceptions about U.S. Health Insurance," *Health Affairs*, 2008.

[21] CBO Director Peter Orszag Testimony before the Senate Finance Committee, June 17, 2008.

[22] Congressional Budget Office. "Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended".

The government would persuade doctors to cut Medicare costs by associating more tests with lower reimbursements. Ranked in order of spending per patient, every year the top 10 percent of physicians would have their reimbursements cut. Since by definition there would always be 10 percent of physicians in the top 10 percent, they would have an incentive to avoid the sickest patients or the specialties with the most tests.

The House Democrats bill plans to expand the Medicaid program to 133 percent of the poverty line in order to cover low-income uninsured workers. Not only would this cause a financial drain on already-strained budgets, but Medicaid does not provide as high a level of care as do many other private plans. Low-income Americans would be disadvantaged by being put on Medicaid rather than being given a refundable tax credit to purchase a private plan, as has been suggested by Georgia Congressman Tom Price, himself a physician, in the Empowering Patients First Act.

Many Medicaid patients cannot find doctors who will see them. In California, 49 percent of family physicians do not participate in Medicaid[23] while in Michigan the number of doctors who do not see Medicaid patients has risen from 12 percent in 1999 to 36 percent in 2005[24]. Physicians do not want to take Medicaid patients because of low reimbursement and substantial paperwork. A

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[23] Lisa Backus et al., "Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care," *Journal of General Internal Medicine*, Vol. 16, No. 12. December 2001.
[24] Jay Greene, "Committee looks at taxing Michigan doctors to help avert 12 percent Medicaid cuts," *Michigan State Medical Society*, September 22, 2009. Available at: http://www.msms.org/AM/Template.cfm?Section=Advocacy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=12302

2009 Health Affairs report indicated that Medicaid physician fees increased 15.1 percent, on average, between 2003 and 2008.[25] This was below the general rate of inflation of 20.3 percent, resulting in a reduction in real fees.

The economy-wide effects of health care reform mandates would discourage job creation and incentives to work by raising taxes, thereby making bankruptcies more likely. Health reform is expensive, and some of the bills pay for it through increased taxes. For instance, the House bill relies on income tax surcharges on the most productive workers, bringing the top tax rate to 45 percent, as well as an 8 percent payroll tax on employers who do not offer the right kind of health insurance to their employees. Moreover, anyone who does not sign up for health insurance would face an additional 2.5 percent income tax. Federal taxes are not the whole story. State taxes would take another 9 percent of incomes in states such as Oregon, Vermont and Iowa; Medicare would take another 1.45 percent; and Social Security taxes would add another 6.2 percent up to $107,000. Top tax rates in some states could exceed 55 percent, discouraging work and investment and reducing employment.

The tax penalty for working is even more substantial at the low end of the income spectrum. The staff of the Joint Tax Committee estimated that combined effective income and premium marginal tax rates, including payroll taxes, for poor families of four under the Baucus bill would be substantial, dwarfing rates

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[25] Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008", *Health Affairs*, Vol. 28, No. 3, 2009.

for upper-income individuals. They would reach 59 percent at 150 percent of the poverty line; 49 percent at 250 percent of the poverty line; 39 percent at 350 percent of the poverty line; and 40 percent at 450 percent of the poverty line.[26]

Our tax system should not make it harder for Americans to work. The penalty falls both on those struggling to escape from poverty, and on those who have invested in education, hoping to enter professional and managerial careers. Throughout the income spectrum, higher taxes would exacerbate the penalty for working.

Our health insurance system needs to change, but not in the way envisaged by Congress. Rather than mandating one expensive plan, Congress would do better to change the current health insurance tax credit from employers to individuals and allow people to pick their own portable plans, as they do with other forms of insurance. It is vital that economic growth and upward income mobility continue, and the main route to this progress is an abundant supply of job opportunities. As configured, the three plans under consideration today would cause job loss and impede job creation, increasing the probability of bankruptcy. They would encourage American firms to move abroad, taking jobs to other countries.

Thank you for allowing me to appear before you today. I would be glad to answer any questions.

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[26] Joint Committee on Taxation. "Memo from Thomas A. Barthold to Mark Prater, Tony Coughlan, Nick Wyatt, and Chris Conlin" October 13, 2009. http://hudson.org/files/documents/Response_to_Mark_Prater_Effective_Marginal_Tax_Rates.pdf.

REFERENCES

Aparna Mathur. "Medical Bills and Bankruptcy Filings". American Enterprise Institute, 2006. Available at: http://www.aei.org/docLib/20060719_MedicalBillsAndBankruptcy.pdf

Bureau of Labor Statistics, "The Employment Situation - September 2009", October 2009. Available at: http://www.bls.gov/news.release/pdf/empsit.pdf

Congressional Budget Office, "Effects of Changes to the Health Insurance System on Labor Markets," July 13, 2009. Available at: http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf

Congressional Budget Office. "Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended", October 7, 2009. Available at: http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

CBO Director Peter Orszag, Testimony before the Senate Finance Committee, June 17, 2008.

David Dranove and Michael L. Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affaris, Vol. 25, No. 2, w74-w83, 2006.

David Gross and Nicholas Souleles, "An Empirical Analysis of Personal Bankruptcy and Delinquency," *Review of Financial Studies*, Vol. 15, No.1, 319-347, 2002.

David H. Himmelstein et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine*, Vol. 122, No. 8, 741-746, 2009.

Ezekiel J. Emanuel and Victor R. Fuchs, "Who Really Pays for Health Care Costs," *Journal of the American Medical Association*, March 5, 2008.

Jay Greene, "Committee looks at taxing Michigan doctors to help avert 12 percent Medicaid cuts," *Michigan State Medical Society*, September 22, 2009. Available at: http://www.msms.org/AM/Template.cfm?Section=Advocacy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=12302

Jiaquan Xu, Kenneth D. Kochanek, and Betzaida Tejada-Vera, "Deaths: Preliminary Data for 2007." Division of Vital Statistics, National Vital Statistics Reports, Vol. 58, No. 1, August 19, 2009. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_01.pdf

Katherine Baicker and Amitabh Chandra, "Myths and Misconceptions about U.S. Health Insurance," *Health Affairs*, 2008.

Katherine Baicker and Helen Levy, "Employer Health Insurance Mandates and the Risk of Unemployment," NBER Working Paper No. 13528, October 2007. Available at: http://www.nber.org/papers/w13528.pdf.

Lisa Backus et al., "Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care," *Journal of General Internal Medicine*, Vol. 16, No. 12. December 2001.

Physicians for a National Health Program, "About PNHP". Available at: http://www.pnhp.org/about/about_pnhp.php

Scott Fay et al. "The Household Bankruptcy Decision," *The American Economic Review*, Vol. 92, No. 3, 706-718, 2002.

Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008", *Health Affairs*, Vol. 28, No. 3, 2009.

The Kaiser Family Foundation, "Medicaid's Role for Women," October 2007. Available at: http://www.kff.org/womenshealth/upload/7213_03.pdf

The Kaiser Family Foundation, "Medicare's Role for Women," June 2009. Available at: http://www.kff.org/womenshealth/upload/7913.pdf

The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2009 Annual Survey" September 15, 2009. Available at: http://ehbs.kff.org/pdf/2009/7936.pdf

The Federal Reserve Board, "Survey of Consumer Finances," 2007. Available at: http://www.federalreserve.gov/pubs/oss/oss2/scfindex.html

U.S. Department of Education, National Center for Education Statistics, "Digest of Education Statistics: 2008", March 2009.

U.S. Department of Labor Wage and Hour Division, "Employee Rights under the Fair Labor Standards Act," July 2009. Available at: http://www.dol.gov/esa/whd/regs/compliance/posters/minwagep.pdf

U.S. Senate "Affordable Health Choices Act". 111th Congress, 1st session. S. 1679. Washighton: GPO, September 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1679pcs.txt.pdf

U.S. Senate Committee on Finance, "America's Healthy Future Act of 2009". Available at: http://www.finance.senate.gov/sitepages/leg/LEG percent202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf

U.S. Senate Committee on Finance, "Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage" (News Release), September 16, 2009. Available at: http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf

U.S. House "America's Affordable Health Choices Act of 2009". 111th Congress, 1st session. H.R. 3200. Washighton: GPO, July 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3200ih.txt.pdf

U.S. House Committee on Judiciary, "Conyers Dismayed by Rise in Medical Bankruptcies" (News Release), July 27, 2009. Available at http://judiciary.house.gov/news/090727.html

REAL CLEAR MARKETS

July 30, 2009

The Healthcare Bankruptcy Myth

By Diana Furchtgott-Roth

Few figures in American life have suffered as publicly as Elizabeth Edwards, a cancer survivor whose son was killed in a car accident, the betrayed wife of presidential candidate John Edwards. Like a classic Greek heroine, she has only one flaw: she is too trusting. This week, she was duped into endorsing a flawed bankruptcy study that was transparently intended to support a single-payer health care plan.

In testimony before a subcommittee of the House Judiciary Committee, Mrs. Edwards declared, "Medical debt is, of course, a symptom of larger problems in our health care system-and the solution to medical debt and medical bankruptcy is real health reform that results in affordable, reliable health coverage and affordable health care for all Americans."

Mrs. Edwards based her testimony on a study in the American Journal of Medicine conducted by Dr. David Himmelstein and other researchers from Harvard University and Ohio University. An unassuming reader might conclude that medical debts are the major cause of personal bankruptcy in America, because the study finds that 62% of bankruptcies in 2007 were "medical."

House Judiciary Chairman John Conyers of Michigan, who should know better, said "This surge in medical bankruptcies demonstrates why health care reform is urgently needed right now. So many people's lives are uprooted, and their financial security destroyed, by unexpected medical costs."

But fewer than one percent of Americans enter bankruptcy each year. Of those, only three to five percent are plausibly bankrupt due to medical debt. These numbers present the inconvenient truth that our health system is not leading to bankruptcy in America.

The Himmelstein study paints a picture of an American middle class that even with health insurance coverage is being bankrupted by health care costs. The share of bankruptcies attributable to health care costs rose by 50%between 2001 and 2007, according to the study. The message is that rising health care costs bankrupt the insured middle class as well as the uninsured lower class.

The only problem is that the study is fatally flawed. Dr. Himmelstein is a co-founder of Physicians for a National Health Program, an organization that describes itself on its Web site as "the only national physician organization in the United States dedicated exclusively to implementing a single-payer national health program." An additional Harvard coauthor, Dr. Steffie Woolhandler, is co-founder and secretary of the organization. Even though the article states on the front page that the authors have no conflict of interest, two are self-declared activists for single-payer health care, and they have twisted the data to fit their cause.

Aparna Mathur, an American Enterprise Institute research fellow and another witness in the hearing, told me in a telephone conversation that "the Himmelstein surveys overstate the effect of medical debts on bankruptcy. Despite obvious problems with the survey methodology, it was clear to me during the testimony yesterday that the study was being used as a pretext for making the case for universal health insurance."

Dr. Himmelstein's study contradicts the economics literature on personal bankruptcies. Most reputable studies are based on the Survey of Consumer Finances, published by the Federal Reserve, which lists different types of consumer debt. Medical debt rose slightly from 5.5% of all debt in 2001 to 5.8% of all debt in 2007, according to the Fed.

A study by the Department of Justice examined more than 5,000 bankruptcy cases between 2000 and 2002. It found that 54% of bankruptcies involve no medical debt, and more than 90% have medical debt of less than $5,000. Even among the minority of bankruptcies that report medical debt, only a few have enough to cause personal bankruptcy.

Dr. Himmelstein gets different results because he uses a smaller sample and a different methodology than other studies. He started with a random sample of 5,251 bankruptcy petitions and wound up through a series of screenings only using 1,032. His survey assumes that when a medical problem is mentioned that associated medical costs are automatically associated with

bankruptcy. In addition, anyone is counted as medically bankrupt if they cite illness or medical bills as a reason for bankruptcy, even if other debts, such as foreclosure and credit card debt, are a primary reason.

Furthermore, if respondents lost two weeks of work due to illness or injury they were counted as medically bankrupt, even if they had no medical debt. Hypothetically, someone could go into bankruptcy while on Medicare or Medicaid, even if they owed no medical bills at all.

Yet using Dr. Himmelstein's methodology, even single-payer health care would not solve the medical bankruptcy problem. People would still lose work time to illness, perhaps even more time than under the current system, because health care would be of lower quality. Under Britain's single-payer system, for example, people who think they might have swine flu are not being seen by doctors. Instead, they are asked to stay home and consult with the doctor over the phone.

More and more Americans understand that adding $1 trillion to government spending for health care reform won't fix our economic crisis. So proponents of single-payer health care bring out poor Elizabeth Edwards to justify their made-up numbers on medical bankruptcy. Shame on them.

Diana Furchtgott-Roth is a contributing editor of RealClearMarkets and an adjunct fellow at the Manhattan Institute.

The Household Bankruptcy Decision

By SCOTT FAY, ERIK HURST, AND MICHELLE J. WHITE*

Personal bankruptcy filings have risen from 0.3 percent of households per year in 1984 to around 1.35 percent in 1998 and 1999, transforming bankruptcy from a rare occurrence to a routine event. Lenders lost about $39 billion in 1998 due to personal bankruptcy filings.[1] But economists have little understanding of why households file for bankruptcy or why filings have increased so rapidly. Until very recently, studying the household bankruptcy decision was very difficult, because no household-level data set existed that included information on bankruptcy filings. In this paper, we use new data from the Panel Study of Income Dynamics, which includes information on bankruptcy filings, to estimate a model of households' bankruptcy decisions.

We find support for the strategic model of bankruptcy, which predicts that households are more likely to file when their financial benefit from filing is higher. Our model predicts that an increase of $1,000 in households' financial benefit from bankruptcy would result in a 7-percent increase in the number of bankruptcy filings. Our model also predicts that if the 1997 National Bankruptcy Review Commission's proposed changes in bankruptcy exemption levels were implemented, there would be a 16-percent increase in the number of bankruptcy filings each year. But if the $100,000 cap on homestead exemptions recently passed by the U.S. Senate were adopted, our model predicts that there would be only a negligible effect on the number of filings. We find little support for the nonstrategic model of bankruptcy which predicts that households file when adverse events occur which reduce their ability to repay. Finally, controlling for state and time fixed effects, our model shows that households are more likely to file for bankruptcy if they live in districts with higher aggregate filing rates.

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[1] This figure is based on unsecured debt per bankruptcy filing of $28,000 (John M. Barron and Michael Staten, 1998).

I. U.S. Personal Bankruptcy Law

The United States has two different personal bankruptcy procedures—Chapter 7 and Chapter 13—and debtors have the right to choose between them.

Chapter 7.—Under Chapter 7, unsecured debts such as credit card debt, installment loans, medical bills, and damage claims are discharged. Debtors are not obliged to use any of their future earnings to repay their debt, but they are obliged to turn over all of their assets above a fixed exemption level to the bankruptcy trustee. The trustee liquidates the nonexempt assets and uses the proceeds to repay creditors. Although bankruptcy is a matter of federal law and the rules are uniform across the United States, Congress gave the states the right to adopt their own bankruptcy exemptions. Most states have separate exemptions for equity in the debtor's principle residence (the "homestead exemption") and for several types of personal property. In general, states' nonhomestead exemptions are low, but their homestead exemptions vary widely, from a few thousand dollars to unlimited in nine states.[2] If debtors' assets are less than the exemption levels in their states, then they are not obliged to repay anything to creditors.

[2] The average value of all nonhomestead exemptions in 1995 was $5,000. The average homestead exemption in 1995 for states that do not have unlimited homestead exemptions was $25,000. Most states also exempt clothing, furniture, and household goods.

Households' financial benefit from filing for bankruptcy under Chapter 7 is therefore the value of debt discharged and their financial cost is the value of nonexempt assets, if any, that they must give up. Households' net financial benefit from filing for bankruptcy is the difference. Households that file for bankruptcy must also pay bankruptcy court filing fees and lawyers' fees. They also face possible nonpecuniary costs, including the cost of acquiring information about the bankruptcy process, higher future borrowing costs, and the cost of bankruptcy stigma.

Chapter 13.—Chapter 13 bankruptcy is intended for debtors who earn regular incomes. Under it, debtors do not give up any assets in bankruptcy, but they must propose a plan to repay a portion of their debts from future income, usually over three to five years. The plan goes into effect as long as the bankruptcy judge accepts it, i.e., creditors do not have the right to block repayment plans.

Because debtors have the right to choose between Chapters 7 and 13, they have a financial incentive to choose Chapter 7 whenever their assets are less than their state's exemption, since doing so allows them to avoid repaying their debts completely.[3] Even when households file under Chapter 13, they are obliged to use future earnings to repay debt only to the extent that they would be obliged to use nonexempt assets to repay debt under Chapter 7. For example, debtors who have $5,000 in nonexempt assets are obliged to repay only the equivalent of $5,000 from future earnings in a repayment plan under Chapter 13. Debtors who have no nonexempt assets sometimes file under Chapter 13, but propose to repay only token amounts. Bankruptcy judges vary in their willingness to accept these plans.[4]

II. Literature Review

Attempts to study the bankruptcy filing decision have been hampered by the lack of household-level data on bankruptcy filings. In an early study, White (1987) regressed the aggregate bankruptcy filing rate by county on the bankruptcy exemption level for the relevant state and other variables. She found that the bankruptcy filing rate was positively and significantly related to the exemption level.[5] Ian Domowitz and Robert L. Sartain (1999) got around the lack of household-level data on bankruptcy filings by combining two data sources: a sample of households that filed for bankruptcy under Chapter 7 in the early 1980's and a representative sample of U.S. households which includes detailed financial information (the 1983 Survey of Consumer Finances). They found that households with more credit card debt were more likely to file for bankruptcy. David Gross and Nicholas Souleles (2002) used a data set of individual credit card accounts to explain account holders' bankruptcy decisions. Their main explanatory variable is lenders' rating of individual account holders' riskiness and their main finding is that, after controlling for the increase in the average borrower's riskiness, the probability of default rose significantly between 1995 and 1997. They interpret this result as evidence that the level of bankruptcy stigma has fallen. Neither the Domowitz and Sartain nor the Gross and Souleles papers tested whether households' decisions to file for bankruptcy are related to their financial benefit from filing, which is a central goal of this study.[6]

[3] Debtors may shift assets from nonexempt to exempt categories before filing or use other strategies to reduce their nonexempt assets before filing. Debtors may also default on their debt but not file for bankruptcy, since creditors do not always attempt to collect. See White (1998a) for discussion.

[4] About 70 percent of bankruptcy filings occur under Chapter 7. Congress has attempted to make Chapter 13 more attractive to debtors by allowing some types of debts—including some student loans and debts incurred by fraud—to be discharged under Chapter 13, but not under Chapter 7. Debtors are also allowed to file under Chapter 13 as often as every six months, while they cannot file under Chapter 7 more often than once every six years. Chapter 13 is also attractive to debtors who own homes and are in arrears on mortgage payments, because it delays foreclosure. In 1984, Congress adopted a provision intended to prevent high-income debtors from filing under Chapter 7, but later court decisions and lack of enforcement made it ineffective. See Karen Gross (1986), Wayne R. Wells et al. (1991), and White (1998b) for discussions of this provision and the relationship between Chapters 7 and 13.

[5] Frank H. Buckley and Margaret F. Brinig (1998) did a similar study using state rather than county bankruptcy filing rates, for the years 1980 to 1991. They found a negative relationship between state aggregate filing rates and the exemption level.

[6] For theoretical models of the bankruptcy decision, see Samuel A. Rea, Jr. (1984) and Ronald A. Dye (1986). Buckley (1994) discusses explanations for the pro-debtor tilt of U.S. bankruptcy policy. Reint Gropp et al. (1997)

There is also a sociologically oriented literature on the bankruptcy filing decision. Teresa A. Sullivan et al. (1989) examined the characteristics of a sample of households that filed for bankruptcy during the early 1980's. Based on descriptive evidence, they argued that households file for bankruptcy when unexpected adverse events occur which reduce their ability to repay their debts. Sullivan et al. also argue that households do not take financial benefit into account in making their bankruptcy decisions. We test the adverse events hypothesis in our empirical work.[7]

Finally, evidence from several sources suggests that the administration and practice of bankruptcy law vary across bankruptcy districts, which may cause incentives to file for bankruptcy to vary across districts. Jean Braucher (1993) interviewed bankruptcy lawyers in four bankruptcy districts and found that they often discourage debtors who have less than a minimum amount of dischargeable debt from filing for bankruptcy, but the minimum amount varies across districts. Braucher also notes that bankruptcy trustees in each district set standard legal fees for Chapter 7 and Chapter 13 bankruptcy filings. Because these fees vary widely across districts, lawyers' incentives to specialize in bankruptcy cases also vary across districts. Both Braucher and Sullivan et al. (1989) have noted that there are large variations across bankruptcy districts in the proportion of filings that occur under Chapter 13, which they attribute to judges or lawyers in particular districts encouraging debtors to file under Chapter 13. But pressure to file under Chapter 13 could make filing for bankruptcy either more or less attractive overall, depending on whether bankruptcy judges in the district are willing to accept token repayment plans under Chapter 13. In our empirical work, we test whether the individual households' decisions to file for bankruptcy are influenced by the number of bankruptcy filings in their districts.

investigate the effect of variations in bankruptcy exemptions on supply and demand for consumer credit.

[7] A *Washington Post* (February 18, 2000) editorial arguing against changing current bankruptcy law suggests that this is a commonly held view: "Most bankruptcies are triggered by misfortune, not irresponsibility: by illness, a job loss, a broken marriage. America should remain the home of second chances."

III. Data and Specification

In 1996, the Panel Study of Income Dynamics (PSID) asked respondents whether they had ever filed for bankruptcy and, if so, in what year(s). Our data set is a combined cross-section, time-series sample of PSID households in the years 1984–1995. We run probit regressions explaining whether household i filed for bankruptcy in year t.[8]

The independent variables test three hypotheses: whether households are more likely to file for bankruptcy as their net financial benefit from filing increases, whether (controlling for financial benefit) they are more likely to file for bankruptcy when adverse events occur, and whether households' bankruptcy decisions are influenced by average bankruptcy filing rates in the localities where they live.

A. *Financial Benefit*

Consider first the hypothesis that households are more likely to file for bankruptcy as their net financial benefit from filing increases. As discussed above, household i's net financial benefit from filing for Chapter 7 bankruptcy in year t is:

(1)

$$FinBen_{it} = \max[D_{it} - \max[W_{it} - E_{it}, 0], 0]$$

where D_{it} is the value of household i's unsecured debt that would be discharged in bankruptcy in year t, W_{it} is household i's wealth in

[8] In order for particular households to be included in our sample, they must have answered all of the PSID questionnaires for the years 1992–1995. Households that are in the sample for 1992–1995 are also included for any of the additional years 1984–1991 for which data are available. We used a balanced panel for the years 1992–1995 because the PSID data sets for 1993–1996 are only available in "early release" form and no household weights are included. We therefore used 1992 household weights for all of the 1993–1995 observations. The "early release" data sets also omit households' state of residence. As a result, we are forced to assume that households observed in 1993–1995 still live in the same state where they lived in 1992. We used the confidential PSID geocodes to assign households to their counties of residence in each year of the sample (up to 1992). This allows us to assign households to bankruptcy districts and also to use county-level data for the unemployment rate. Because we use the PSID weights, our sample is representative of the general population.

year t net of secured debts such as mortgages and car loans, and E_{it} is the bankruptcy exemption in household i's state of residence in year t. When household i files for bankruptcy, debts of D_{it} are discharged, but the household must give up assets of value $W_{it} - E_{it}$ if its wealth W_{it} exceeds the exemption level E_{it}. $FinBen_{it}$ must be nonnegative, since households would not file for bankruptcy if their nonexempt assets exceeded the amount of debt discharged. Although equation (1) gives the financial benefit of filing under Chapter 7, it also applies to filing under Chapter 13, because—as discussed above—households have a choice between the two procedures and their financial benefit from filing under Chapter 13 is closely related to their financial benefit from filing under Chapter 7.

To calculate financial benefit, we obtained exemption levels by state from 1984–1995 for equity in owner-occupied homes, equity in vehicles, and personal property applicable to financial assets, plus the wild card exemption (which can be applied to any asset). The bankruptcy exemption variable E_{it} is assumed to equal the sum of these exemptions if the household owns its own home or the sum of the vehicle, personal property, and wild card exemptions if the household rents. Since most states allow married couples who file for bankruptcy to take higher exemptions, we also adjust the exemption levels by the appropriate amount if the household contains a married couple. If the state's homestead exemption is unlimited and the household owns its own home, we assume that the value of the homestead exemption equals the value of the household's home.[9] Sixteen states also allow their residents to choose between the state's exemption and a uniform federal bankruptcy exemption. For residents of these states, we use the larger of the state or the federal exemption.[10]

The other variables needed to calculate net financial benefit, D_{it} and W_{it}, are taken from the PSID. The PSID asks questions concerning the amount of unsecured debt and the value of nonhousing wealth only as part of the wealth supplements, which were conducted in 1984, 1989, and 1994, but it asks the value of housing equity every year. We use 1984, 1989, and 1994 data on unsecured debt to construct D_{it} for each of the years 1984–1988, 1989–1993, and 1994–1995, respectively. Household i's wealth in year t, W_{it}, equals the value of housing equity in year t plus the value of nonhousing assets from the most recent wealth survey prior to year t. The fact that data on unsecured debt and nonhousing assets are only available in five-year increments means that our measure of financial benefit is subject to measurement error.[11]

We include both financial benefit and financial benefit squared as regressors in our model of the bankruptcy filing decision in order to test for potential nonlinearities in the effect of financial benefit on the bankruptcy decision.

B. *Adverse Events*

The nonstrategic view of bankruptcy is that households do not plan in advance for bankruptcy and do not respond to financial gain in deciding whether to file. Instead, they file in response to unanticipated adverse events which reduce their ability to repay their debts. We would like to test the nonstrategic model of bankruptcy against the strategic model just discussed. A strict interpretation of the nonstrategic model implies that income should be negatively and significantly related to the probability of filing for bankruptcy, because income measures ability to repay debt. But financial benefit should not be significantly related to the probability of filing, because households' financial benefit from filing depends only on their wealth and not on their incomes. Conversely, a strict interpretation of the strategic model implies

[9] This assumes that households take advantage of the various bankruptcy exemptions by converting assets from nonexempt to exempt categories where possible.

[10] In the 1978 Bankruptcy Code, Congress adopted a uniform federal bankruptcy exemption, but permitted states to opt out of the federal exemption by adopting their own exemptions. All states had done so by 1983, but about one-third of the states allow their residents to choose between the state and the federal exemptions. Since the early 1980's, the pattern has been that states change their exemption levels only rarely—mainly to correct nominal exemption levels for inflation. Because of this, we treat the exemption levels as exogenous.

[11] See our working paper, Fay et al. (1998), for discussion of how measurement error might bias our findings of the marginal effect of changes in financial benefit on households' probability of filing for bankruptcy and a test for the effect of measurement error. We find that measurement error does not significantly affect our results.

that the financial benefit variable should be positively and significantly related to the probability of filing for bankruptcy, but income should not, because income is unrelated to the financial gain from bankruptcy. Thus a regression of income and financial benefit on whether households file for bankruptcy should allow us to distinguish between the theories.

However, mismeasurement of wealth is likely to prevent us from cleanly distinguishing between the two theories. As discussed above, our measure of financial benefit relies on wealth data which is only collected at five-year increments. Since current income acts as a proxy for the change in wealth since the last time the PSID collected wealth data, a finding that income is significantly related to the probability of filing for bankruptcy could support either theory.[12]

In our base-case specification, we include as regressors household i's income in year $t - 1$ and the reduction in household i's income between year $t - 2$ and year $t - 1$ if income fell, or else zero. We also estimate a version of our model that excludes the income variables, but includes direct measures of whether adverse events occurred.

C. *Local Trends*

We also test whether households' bankruptcy filing decisions are influenced by the aggregate bankruptcy filing rates in their localities in the previous year. As discussed above, there are differences in the way bankruptcy law is administered and practiced across bankruptcy districts which make filing persistently more attractive in certain districts. Because we include state fixed effects in our regressions, persistent differences between the district and the national filing rates will be captured by the state fixed effects, except to the extent that districts' filing rates differ from their states' filing rates. However, an increase in a district's filing rate may also start an information cascade which causes the trend of bankruptcy filings in the district to differ from the national trend. A survey of recent bankruptcy filers by Visa U.S.A., Inc. (1997) found that half of them first heard about bankruptcy from friends or relatives. Also, respondents reported that they were very apprehensive about filing for bankruptcy beforehand, but found the actual process of filing much quicker and easier than they expected. If households live in a district with a higher bankruptcy filing rate, then they are more likely to hear firsthand about bankruptcy from friends or relatives because the latter are more likely to have filed. Their friends/relatives will probably tell them that filing for bankruptcy is quick and easy. This information will tend to make households more comfortable with the idea of bankruptcy, so that the level of bankruptcy stigma falls and individual households' probabilities of filing rise. Higher filing rates then continue the process of shifting attitudes toward a more favorable view of bankruptcy.

We test for local trends in the bankruptcy filing rate by entering the aggregate filing rate in the household's bankruptcy district the previous year.[13] Because we also include state and year fixed effects in our regressions, the coefficient of the lagged aggregate bankruptcy filing rate tests whether households are more likely to file for bankruptcy if they live in districts with higher aggregate filing rates, controlling for persistent differences across states in bankruptcy filing rates and for the national trend in bankruptcy filing rates. A significant coefficient on the lagged bankruptcy filing rate in the district could reflect local differences in the level of bankruptcy stigma or local differences in the administration of bankruptcy law that make the district differ from the state, or could reflect the influence of information cascades.

D. *Other Variables*

We include a vector of demographic variables which may be related to households' decisions to file for bankruptcy. These are the age and age squared of the household head, the head's education level, family size, whether the household owns its own home, and whether the household head or spouse owns a business. The

[12] Hurst et al. (1998) show that over 35 percent of five-year wealth changes in the PSID can be explained by household income, age, education, race, and initial wealth.

[13] Bankruptcy court districts are the same as federal district court districts. There are 90 individual bankruptcy court districts, with one to four districts in each state. We are grateful to Ted Eisenberg for providing us with a program which assigns counties to federal court districts.

probability of filing for bankruptcy is likely to be increasing in the head's age since age brings increasing access to credit, but eventually the effect should reverse as households accumulate wealth and demand less credit. The predicted effect of being a homeowner is ambiguous. Households that have home equity greater than the homestead exemption have an incentive not to file because they must give up their homes in bankruptcy. However homeowners who have fallen behind on their mortgage payments can benefit from filing for bankruptcy, since filing delays foreclosure. The business ownership variable is particularly of interest since those who own businesses presumably have greater variance of wealth and are less risk averse than households in general. Both of these factors tend to increase the probability of filing for bankruptcy. In addition, owners of failed businesses have a particularly strong incentive to file, because business debts are discharged in bankruptcy along with unsecured personal debts. We expect households that own businesses to be more likely to file for bankruptcy.

As an inverse proxy for legal fees in filing for bankruptcy, we include the number of lawyers per 1,000 population in household i's state of residence in year t. Where there are more lawyers per capita, there is likely to be more competition among lawyers and more advertising of bankruptcy by lawyers, both of which cause legal fees and the costs of becoming informed about bankruptcy to fall. The lawyers per capita variable is predicted to be positively related to the probability of filing for bankruptcy.[14]

We also include several state- or county-level variables: the change in average income in household i's state of residence between years $t-1$ and t, the standard deviation of income per capita in the state (calculated over the period 1980 to 1995), and the unemployment rate in household i's county of residence in year t.

[14] The bankruptcy court filing fee is uniform across the country but varies over time, so that it is captured by the year fixed effects. Another cost of filing for bankruptcy is the loss of future access to credit. We assume that this cost is proxied by household demographic characteristics and by aggregate market conditions. Because markets for mortgages and consumer credit are national, we assume that future borrowing costs do not differ across localities. (See Staten [1993] for a survey of bankrupts which showed that 73 percent were able to obtain credit within a year after their bankruptcy filings.)

TABLE 1—THE PERCENTAGE OF HOUSEHOLDS THAT FILED FOR BANKRUPTCY BY YEAR

Year	All U.S. households (percent)	PSID sample (percent)
1984	0.33	0.09
1985	0.39	0.34
1986	0.51	0.21
1987	0.55	0.10
1988	0.60	0.33
1989	0.66	0.37
1990	0.77	0.41
1991	0.93	0.31
1992	0.94	0.39
1993	0.84	0.33
1994	0.80	0.42
1995	0.88	0.41

Sources: The number of U.S. nonbusiness bankruptcy filings comes from the Administrative Office of the U.S. Courts and the number of U.S. households comes from the *Statistical Abstract of the United States* (U.S. Department of Commerce, 1997).

These variables capture differences in macroeconomic conditions across bankruptcy districts or unobserved changes in wealth or other variables that affect the bankruptcy decision and are correlated with state or district economic activity. Finally we include state and year fixed effects.[15]

IV. Results

Table 1 gives the percent of households that filed for bankruptcy each year from 1984 to 1995 for both our sample and for U.S. households overall. It should be noted that our sample contains only 254 bankruptcy filings. Over the period 1984–1995, the national bankruptcy filing rate rose from 0.33 percent to 0.88 percent, with most of the increase coming in the 1980's. While the correlation between the national bankruptcy filing rate and the PSID filing rate is 0.67, the PSID filing rate is only about half as high as the national rate.[16]

[15] We could not include other legal variables, such as whether household i's state prohibits wage garnishment, because few states changed their garnishment rules during our period. The effects of state-level legal rules and other differences across states are captured by the state fixed effects.

[16] Applying the analysis of J. A. Hausman et al. (1998) to our data implies that, if the number of households who reported no bankruptcy but actually went bankrupt is small relative to the number of households that actually did not

TABLE 2—THE PERCENTAGE OF HOUSEHOLDS THAT WOULD BENEFIT FINANCIALLY FROM FILING FOR BANKRUPTCY

Financial gain ($FinBen_{it}$)	1984	1989	1994	All years
Greater than $0 (percent)	17.9	18.6	16.8	18.5
Greater than $2,500 (percent)	10.6	8.8	11.8	10.0
Greater than $10,000 (percent)	3.1	2.5	4.8	3.1
Median	−$27,000	−$29,000	−$34,000	−$26,000
Mean	−$145,000	−$160,000	−$162,000	−$144,000

Notes: $FinBen_{it}$ equals the value of household i's debt that would be discharged if it filed for bankruptcy in year t minus the value of household i's nonexempt assets in year t. $FinBen_{it}$ must be nonnegative. All dollar values are in 1996 dollars.

Table 2 gives information concerning the distribution of households' financial benefit from bankruptcy ($FinBen_{it}$) for the years in which the PSID collected wealth data (1984, 1989, and 1994). About 18 percent of households would gain financially if they filed. About 10 percent of households would gain $2,500 or more and therefore have a substantial incentive to file. Overall, a much larger proportion of households has a financial incentive to file for bankruptcy than actually files each year. Of the households that would not gain from filing for bankruptcy, many have no unsecured debts and no nonexempt assets. These results are similar to those found by White (1998a) in calculations using the 1992 Survey of Consumer Finance, which contains much more detailed wealth data.

Table 3 gives summary statistics.

Regression 1 in Table 4 gives the results of a probit regression that explains whether household i filed for bankruptcy in year t as a function of financial benefit, financial benefit squared, and other variables.[17] The coefficient of $FinBen_{it}$, the net financial benefit of bankruptcy, is positive and highly statistically significant ($p < 0.001$).[18] The coefficient of $FinBen_{it}^2$ is small and negative, but is also statistically significant ($p = 0.010$).[19] The positive sign and statistical significance of $FinBen_{it}$ provides strong support for the hypothesis that households respond to financial incentives in making their bankruptcy decisions. The lagged aggregate bankruptcy filing rate in the household's district is positive as predicted and statistically significant ($p = 0.023$). We discuss the marginal effects of these variables in the next section.[20]

Both household income and the reduction in income are negatively related to the probability of filing for bankruptcy and statistically significant ($p < 0.001$ for both). Because income and the reduction in income could be acting as proxies for unmeasured changes in wealth for the years in which the PSID did not collect

file for bankruptcy, as it presumably is in our data, then the underreporting of bankruptcy filings will lead to a slight downward bias in our estimated coefficients.

[17] See Robert Moffitt (1981) and Orley Ashenfelter (1983) for discussion of the problems of estimating individual households' participation in social programs when participation is voluntary, but the program imposes an implicit tax on the earnings of those who choose to participate. However, the bankruptcy filing decision differs from the decision to participate in income maintenance programs since filing for bankruptcy under Chapter 7 does not impose a tax on debtors' future earnings. Filing for bankruptcy under Chapter 13 does impose a tax on future earnings, but the tax rate varies and is strongly influenced by debtors' option to file under Chapter 7.

[18] Standard errors are corrected using the Huber/White procedure, which allows error terms for the same individual to be correlated over time.

[19] The negative coefficient of $FinBen_{it}^2$ probably results from the fact that a few households in the data set did not file for bankruptcy despite having very large positive financial benefit.

[20] We would have liked to take advantage of the panel aspect of our data by differencing out the individual-specific component of the bankruptcy decision. But running a discrete choice model with individual fixed or random effects can be extremely problematic (see William Greene, 1993). Gary Chamberlain (1980) suggested a method for estimating a conditional likelihood logit with individual fixed effects, in which only within-individual variation contributes to the likelihood. But because relatively few households file for bankruptcy, this method is not well suited to our data.

TABLE 3—VARIABLE MEANS FOR THE PSID BANKRUPTCY SAMPLE

Variable	Mean value	Standard deviation
Financial benefit ($FinBen_{it}$)	−$146,000	608,000
Financial benefit (if $FinBen_{it} > 0$)	$7,813	27,600
Debts (if $FinBen_{it} > 0$)	$9,329	31,800
Nonexempt assets (if $FinBen_{it} > 0$)	$585	15,000
Lagged bankruptcy rate	0.02312	0.0138
Household labor income	$27,570	37,100
Reduction in income	−$3,438	15,300
Age of household head	47.26	17.00
Years of education of household head	12.27	4.68
Family size	2.66	1.48
Own business[a]	0.123	0.329
Own home[a]	0.656	0.475
Lawyers per capita	0.286	0.0938
State income growth	0.058	0.029
State income deviation	4.06	0.956
Head divorced during previous year[a]	0.034	0.181
Unemployment during previous year[a]	0.042	0.202
Health problems during previous year[a]	0.071	0.257

Notes: The lagged bankruptcy rate is the aggregate bankruptcy filing rate in household i's bankruptcy district in the previous year. The reduction in income equals the amount that household i's income fell from year $t-2$ to year $t-1$, if income fell, or else zero. Lawyers per capita is the number of lawyers per capita in household i's state of residence in year t. State income deviation is the standard deviation of average income in household i's state of residence, calculated over the period 1980–1995.

[a] Indicates a dummy variable (yes = 1).

wealth data, these results do not allow us to distinguish between the strategic versus the nonstrategic models of the bankruptcy decision. Of the demographic variables, the age of the household head, age squared, the head's education level, and family size are all statistically significant and all have the predicted signs.

The dummy variable for whether the household owns its own home is negative and marginally significant ($p = 0.080$).[21] The dummy variable for owning a business has the expected positive sign, but is not statistically significant. The number of lawyers per 1,000 population in households' state of residence—our proxy for legal costs—is negative rather than positive as predicted, but not significant. None of the macroeconomic variables that we included as additional controls were statistically significant.

Regression I imposes the restriction that the two components of $FinBen_{it}$ and $FinBen_{it}^2$, unsecured debts that would be discharged in bankruptcy and nonexempt assets that must be given up in bankruptcy, must have coefficients of the same absolute value but opposite signs. In regression II, we relax this restriction. We therefore drop $FinBen_{it}$ and $FinBen_{it}^2$ from the model. We replace them with debts for households that have positive financial benefit from bankruptcy, or else zero, and nonexempt assets for households that have positive financial benefit from bankruptcy, or else zero. [See equation (1).] We also include debts squared, nonexempt assets squared, and an interaction term between debts and nonexempt assets. If debts and nonexempt assets affect the bankruptcy decision equally, then the predictions are that the coefficients of debts and nonexempt assets will be equal in magnitude but opposite in sign, the coefficients of debts squared and nonexempt assets squared will be equal in magnitude and the same sign, and the coefficient of the interaction term will be twice as large and of the opposite sign as the coefficients of debts squared or nonexempt assets squared.

The results are given in regression II of Table 4. They show that the coefficient of debts is positive as predicted and statistically significant, but the coefficient of nonexempt assets is positive—rather than negative as predicted—and insignificant. We can marginally reject the null hypothesis that the two coefficients have the same value but opposite signs using a Wald test ($p = 0.082$). It should be noted that the coefficient of debts in regression II is similar to the coefficient of $FinBen_{it}$ in regression I ($4.76e^{-5}$ versus $5.66e^{-5}$). The coefficient of debts squared is negative and statistically significant and the coefficient of nonexempt assets squared is also negative, but not significant. We cannot reject the null hypothesis that the two coefficients are the same ($p = 0.335$). Finally, the interaction term is negative as predicted, but insignificant. We cannot reject the null hypotheses that −2 times the coefficient of the interaction term equals the coefficient of debts

[21] Domowitz and Sartain (1999) also found that homeowning was negatively related to the bankruptcy filing decision.

TABLE 4—RESULTS EXPLAINING WHETHER HOUSEHOLDS FILE FOR BANKRUPTCY

	I		II		III	
Variable	Coefficient	Standard error	Coefficient	Standard error	Coefficient	Standard error
Constant	−2.24	0.541	−2.23	0.541	−1.95	0.524
Financial benefit	5.66×10^{-5}	1.15×10^{-5}	—	—	5.61×10^{-5}	1.14×10^{-5}
(Financial benefit)^2	-1.04×10^{-9}	4.04×10^{-10}	—	—	-1.03×10^{-9}	4.00×10^{-10}
Debts (if $FinBen_{it} > 0$)	—	—	4.76×10^{-5}	1.05×10^{-5}	—	—
Nonexempt assets (if $FinBen_{it} > 0$)	—	—	1.59×10^{-4}	1.18×10^{-4}	—	—
(Debts)^2	—	—	-7.54×10^{-10}	3.32×10^{-10}	—	—
(Nonexempt assets)^2	—	—	-5.27×10^{-9}	4.67×10^{-9}	—	—
Interaction term	—	—	-1.10×10^{-8}	1.56×10^{-8}	—	—
Lagged bankruptcy rate	5.92	2.60	5.84	2.58	5.78	2.59
Household labor income	-5.34×10^{-6}	1.42×10^{-6}	-5.42×10^{-6}	1.42×10^{-6}	—	—
Reduction in income	-2.15×10^{-6}	6.00×10^{-7}	-2.15×10^{-6}	5.97×10^{-7}	—	—
Age of household head	0.030	0.014	0.030	0.014	0.018	0.013
(Age)^2	-4.89×10^{-4}	1.55×10^{-4}	-4.95×10^{-4}	1.56×10^{-4}	-3.52×10^{-4}	1.47×10^{-4}
Years of education	−0.029	0.012	−0.029	0.012	−0.037	0.011
Family size	0.038	0.017	0.037	0.017	0.032	0.017
Own business	0.035	0.092	0.038	0.092	0.092	0.090
Own home	−0.131	0.075	−0.125	0.075	−0.192	0.068
Lawyers per capita	0.413	0.804	0.415	0.808	−0.535	0.797
County unemployment rate	−0.009	0.016	−0.008	0.016	−0.005	0.016
State income growth	−1.93	1.19	−1.87	1.19	−1.84	1.18
State income deviation	−0.128	0.091	−0.130	0.091	−0.134	0.091
Divorce	—	—	—	—	0.228	0.129
Period of unemployment	—	—	—	—	0.110	0.123
Health problems	—	—	—	—	0.092	0.117
State fixed effects	yes		yes		yes	
Year fixed effects	yes		yes		yes	

Notes: The sample size for all regressions is 55,487. All regressions use the PSID family weights. Standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.

squared or nonexempt assets squared (p = 0.466 and 0.439, respectively).[22] These results suggest that debts and assets play different roles in the bankruptcy decision. For households in our sample, discharge of debts is the dominant financial consideration in the decision to file for bankruptcy, while the obligation to use nonexempt assets to repay debts plays little role.

In regression III, we explore the adverse events hypothesis further by rerunning regression I, but omitting the income and reduction in income variables and introducing dummy variables for adverse events which the household experienced the previous year: health problems for the household head or spouse, spells of unemployment for the head or spouse (if s/he previously worked), and the household head being divorced in the previous year.[23] The results show that all three of the adverse event variables have the predicted positive signs, but only the divorce variable is close to statistical significance (p = 0.077). These results suggest little support for the nonstrategic model of the bankruptcy decision, controlling for the level of financial benefit. The coefficients of the financial benefit variables remain the same as in regression I.[24]

[22] The null hypothesis of no joint significance for debts and nonexempt assets in regression II can be rejected ($p < 0.001$). The null hypothesis of no joint significance for debts squared, nonexempt assets squared and the interaction term can marginally be rejected ($p < 0.078$).

[23] Income and the reduction in income are omitted because they are highly correlated with all three of the adverse events variables.

[24] In addition to divorce reducing ability to pay, the correlation between divorce and bankruptcy may reflect the fact that divorce lawyers often counsel their clients to file for bankruptcy.

TABLE 5—PREDICTIONS

Variable	Hypothesized change	Percentage point marginal effect	Percentage change in the filing rate
Regression I			
Financial benefit	+$1,000	0.021	7.0
		(0.005)	
1997 NBRC proposal	(see text)	0.048	15.9
		(0.011)	
Cap on homestead exemption	(see text)	−0.0014	0.46
		(0.00053)	
Lagged bankruptcy rate	+1 standard deviation = 0.0054	0.094	31
		(0.047)	
Last year's income (increase)	+$10,000	−0.042	−14
		(0.012)	
Last year's income (decrease)	−$10,000	0.086	28.5
		(0.028)	
Years of education	+1 year	−0.024	−8.0
		(0.010)	
Age	+10 years	−0.080	−26.5
		(0.018)	
Regression III			
Divorce	From 0 to 1	0.261	86.5
		(0.200)	

Notes: We compute each household's estimated probability of bankruptcy under the hypothesized change, holding all other household characteristics fixed. The marginal effect is the change in the probability of bankruptcy for that household. We average these marginal effects over all households, using the *PSID* weights, to get the results reported in the middle column. The rightmost column converts these marginal effects into a percentage change in the filing rate by dividing by the average probability of bankruptcy for the sample, which is 0.3017 percent. Figures in parentheses are bootstrapped standard errors, computed using 1,000 repetitions of the sample.

V. Interpretation

Table 5 gives predicted changes in the probability of filing for bankruptcy that result from given hypothetical changes in the values of selected variables, using regression I.

Suppose first that the financial benefit of bankruptcy increased by $1,000 for all households. Then the average household's probability of filing for bankruptcy is predicted to rise by 0.021 percentage points. Since the average probability of filing in our sample is 0.3017 percent, the model predicts that the number of bankruptcy filings would increase by 7 percent per year. Based on 1.3 million bankruptcy filings per year in the United States (the figure for 1999), this implies that about 90,000 additional bankruptcy filings would occur per year.

In 1997, the National Bankruptcy Review Commission proposed the adoption of a uniform national bankruptcy exemption for personal property of $20,000 for homeowners and $35,000 for renters, with both exemptions doubled for married couples who file for bankruptcy. Under the proposal, states would still have the right to adopt their own homestead exemptions, but they could not be less than $20,000 or greater than $100,000. Suppose these proposals went into effect and suppose all states adopted homestead exemptions of $60,000—the midpoint of the allowed range. For each household in our sample, we calculate the resulting change in the financial benefit of filing for bankruptcy and use these figures to calculate the change in each household's probability of filing. (Note that many households' financial benefit from bankruptcy is unaffected by a change in the exemption level, since they have few nonexempt assets.) Because more households benefit from the higher homestead or personal property exemptions under the reform than are harmed by the loss of homestead exemptions exceeding $100,000, the model predicts that the average probability of filing for bankruptcy would rise by 0.048 percentage points. This increase is highly significant, with a bootstrapped standard error of 0.011. It translates into a 15.8-percent increase in the number

of bankruptcy filings, or 205,000 additional bankruptcy filings each year.

The bankruptcy reform bill passed by the U.S. Senate in the spring of 2000 (S. 945, "Consumer Bankruptcy Reform Act of 1999") proposed a more modest change: homestead exemptions would be capped at $100,000. If we assume that this provision went into effect but all other aspects of bankruptcy law remained the same, then the model predicts that bankruptcy filings would fall by 0.0014 percentage points or by less than 0.5 percent. As a result, there would be about 6,000 fewer filings per year. This reform has such a modest effect because only 7 percent of households live in states with unlimited homestead exemptions and few of these households have dischargeable debt in excess of $100,000.

Now turn to the effect of an increase in aggregate bankruptcy filings in household i's district. Suppose a single district in a single year experienced an increase in its bankruptcy filing rate equal to one standard deviation of the average district filing rate, which is 0.0054. Then regression I predicts that the average probability of bankruptcy for households that live in that district would rise by 0.094 percentage points in the following year, implying that the number of bankruptcy filings in the district would increase by 31 percent. These results are consistent with local trends occurring in which increases in a district's bankruptcy filing rate cause attitudes toward bankruptcy to become more favorable and therefore individual households' probabilities of filing rise.

Now suppose average household income rises or falls by $10,000 and consider the effect on bankruptcy filings one year later. The model predicts that an increase in income would lower the bankruptcy filing rate the following year by 0.042 percentage points, or 14 percent; while a decrease in income would raise the bankruptcy filing rate the following year by 0.086 percentage points, or 28 percent. The fall in income has a larger absolute effect on bankruptcy filings in the following year because it is more likely to affect both the income variable and the reduction in income variable. An additional year of education for household heads results in a predicted decline of 8 percent in the probability of bankruptcy, all else equal. If household heads were ten years older, their probability of bankruptcy would fall by 26 percent. Finally, using the results of regression III, when divorce occurs, household heads' probability of filing for bankruptcy is predicted to rise by 86 percent in the following year. Thus divorce has a large effect on bankruptcy filings, even controlling for financial benefit.

VI. Conclusions

In this paper, we estimate a model of the household bankruptcy filing decision, using new data from the PSID on bankruptcy filings. We test whether households are more likely to file for bankruptcy when their financial benefit from filing—equal to the value of debt discharged in bankruptcy minus the value of nonexempt assets that households would have to give up in bankruptcy—rises. We find that an increase of $1,000 in households' financial benefit from bankruptcy is associated with an increase of 0.021 percentage points—or 7 percent—in the probability of bankruptcy, and the relationship is statistically significant. However when we separate financial benefit into debts that would be discharged in bankruptcy versus nonexempt assets that must be given up in bankruptcy, we find that discharge of debt is the dominant consideration in households' decisions to file. We also assess the impact of two proposed changes in bankruptcy exemptions. We find that if the 1997 National Bankruptcy Review Commission's proposals were adopted, there would be 205,000 additional bankruptcy filings each year. In contrast, if the $100,000 cap on homestead exemptions recently passed by the U.S. Senate were adopted, there would be only a negligible effect on the number of bankruptcy filings. We find little support for the alternate hypothesis that households file for bankruptcy when adverse events occur. Even after controlling for state and time fixed effects, households are more likely to file for bankruptcy if they live in districts which have higher aggregate bankruptcy filing rates, which suggests that local trends in bankruptcy filings are an important determinant of whether households file.

An important limitation of our study is that it is based on a relatively small number of bankruptcy filings, while alternate household data sets that include information on bankruptcy filings are not available. This lack of data has meant that, although Congress has hotly

debated bankruptcy reform legislation each of the past several years, economists have been handicapped in their ability to provide good policy advice. Hopefully, better information will be available in the future to study this important issue.

REFERENCES

Ashenfelter, Orley. "Determining Participation in Income-Tested Social Programs." *Journal of the American Statistical Association*, September 1983, *78*(383), pp. 517–25.

Barron, John M. and Staten, Michael E. "Personal Bankruptcy: A Report on Petitioners' Ability-to-Pay." Discussion paper, Credit Research Center, Georgetown University, 1998.

Braucher, Jean. "Lawyers and Consumer Bankruptcy: One Code, Many Cultures." *American Bankruptcy Law Journal*, Fall 1993, *67*, pp. 501–83.

Buckley, Frank H. "The American Fresh Start." *Southern California Interdisciplinary Law Journal*, Fall 1994, *4*, pp. 67–97.

Buckley, Frank H. and Brinig, Margaret F. "The Bankruptcy Puzzle." *Journal of Legal Studies*, January 1998, *27*(1), pp. 187–207.

Chamberlain, Gary. "Analysis of Covariance with Qualitative Data." *Review of Economic Studies*, January 1980, *47*(1), pp. 225–38.

Domowitz, Ian and Sartain, Robert L. "Determinants of the Consumer Bankruptcy Decision." *Journal of Finance*, February 1999, *54*(1), pp. 403–20.

Dye, Ronald A. "An Economic Analysis of Bankruptcy Statutes." *Economic Inquiry*, July 1986, *24*(3), pp. 417–28.

Fay, Scott; Hurst, Erik and White, Michelle J. "The Bankruptcy Decision: The Roles of Financial Benefit and Stigma." Working paper, University of Michigan, 1998.

Greene, William. *Econometric analysis*, 2nd Ed. New York: Prentice-Hall, 1993.

Gropp, Reint; Scholz, John Karl and White, Michelle J. "Personal Bankruptcy and Credit Supply and Demand." *Quarterly Journal of Economics*, February 1997, *112*(1), pp. 217–51.

Gross, David B. and Souleles, Nicholas S. "An Empirical Analysis of Personal Bankruptcy and Delinquency." *Review of Financial Studies*, Spring 2002, *15*(1), pp. 319–47.

Gross, Karen. "Preserving a Fresh Start for the Individual Debtor: The Case of Narrow Construction of the Consumer Credit Amendments." *University of Pennsylvania Law Review*, December 1986, *135*, pp. 59–152.

Hausman, J. A.; Abrevaya, Jason and Scott-Morton, F. M. "Misclassification of a Dependent Variable in a Discrete-Response Setting." *Journal of Econometrics*, December 1998, *87*(2), pp. 239–69.

Hurst, Erik; Luoh, Ming-Ching and Stafford, Frank P. "The Wealth Dynamics of American Families, 1984–94." *Brookings Papers on Economic Activity*, 1998, (1), pp. 267–329.

Moffitt, Robert. "Participation in the AFDC Program and the Stigma of Welfare Receipt: Estimation of a Choice-Theoretic Model." *Southern Economic Journal*, January 1981, *47*(3), pp. 753–62.

National Bankruptcy Review Commission. *Bankruptcy: The next twenty years*. Washington, DC: U.S. Government Printing Office, 1997.

Rea, Samuel A., Jr. "Arm-breaking, Consumer Credit and Personal Bankruptcy." *Economic Inquiry*, April 1984, *22*(2), pp. 188–208.

Staten, Michael. "The Impact of Post-Bankruptcy Credit on the Number of Personal Bankruptcies." Credit Research Center, Krannert Graduate School of Management Working Paper No. 58, Purdue University, 1993.

Sullivan, Teresa A.; Warren, Elizabeth and Westbrook, Jay Lawrence. *As we forgive our debtors: Bankruptcy and consumer credit in America*. New York: Oxford University Press, 1989.

U.S. Department of Commerce. *Statistical abstract of the United States*. Washington, DC: U.S. Government Printing Office, 1997.

Visa U.S.A., Inc. *Consumer bankruptcy: Annual bankruptcy debtor survey*, 1997. [Online: ⟨www.abiworld.org/stats/visa⟩.]

Washington Post. "Bad Ideas on Bankruptcy." 18 February 2000, p. A22.

Wells, Wayne R.; Kurtz, Janell M. and Calhoun, Robert J. "The Implementation of Bankruptcy Code Section 707(b): The Law and the Reality." *Cleveland State Law Review*, 1991, *39*, pp. 15–48.

White, Michelle J. "Personal Bankruptcy Under the 1978 Bankruptcy Code: An Economic Analysis." *Indiana Law Journal*, Winter 1987, *63*(1), pp. 1–53.

_____. "Why Don't More Households File for Bankruptcy?" *Journal of Law, Economics, and Organization*, October 1998a, *14*(2), pp. 205–31.

_____. "Why It Pays to File for Bankruptcy: A Critical Look at the Incentives under U.S. Personal Bankruptcy Law and a Proposal for Change." *University of Chicago Law Review*, Summer 1998b, *65*(3), pp. 685–732.

Investors.com

"Medical Bankruptcies Hyped Up In Study"

By DAVID HOGBERG, INVESTOR'S BUSINESS DAILY

Posted 06/05/2009 07:10 PM ET

While a new study blames medical factors for an increasing share of U.S. bankruptcies, critics accuse the authors of exaggerating, distorting or omitting key facts to advance their policy agenda.

The study, published in the American Journal of Medicine, states that the share of medical-related bankruptcies has risen in the U.S. from about 54% of the total in 2001 to 62% in 2007.

But the authors — who make no secret of their support for a single-payer health care system — fail to mention that the actual number of bankruptcies has fallen sharply over that period, including those medically related. Bankruptcies spiked in 2005 to beat a major reform that it made it harder to file. The authors only noted that bankruptcies have risen from the post-spike plunge.

Most mainstream media uncritically repeated their findings.

"Medical bills are behind more than 60% of U.S. personal bankruptcies," stated a Reuters article on the study in a typical example.

And such studies shape the health care debate on Capitol Hill. Senate Finance Committee Chairman Max Baucus, D-Mont., referred to a 2005 study by the same authors in a health white paper this year.

"Medical debt contributes to half of all filed bankruptcies, and affects approximately 2 million people," he wrote.

Dr. Steffie Woolhandler, one of the study's co-authors, doesn't think health care proposals by Baucus and Sen. Ted Kennedy, D-Mass., would prevent medical bankruptcies.

But, "most of the people in our study would be saved from bankruptcy," if the U.S. switched to a single-payer system, where the government pays most if not all of medical expenses.

She based that on the study's finding that 92% of respondents claimed they had problems with medical bills. But only 29% of debtors blamed such bills for their bankruptcy.

Woolhandler, a physician at Harvard University, is a founder of the Physicians for a National Health Program, a single-payer advocacy group. So is her physician-husband Dr. David Himmelstein, another co-author. The other co-authors are professors Deborah Thorne and Elizabeth Warren. Warren heads a congressional oversight panel for the TARP bailout fund.

That's part of the problem says David Dranove, a professor at Northwestern University.

"What they're trying to claim is that if we had national health insurance, if everyone is covered by a federal program, none of these people would be bankrupt," he said. "But there is nothing in this study that allows us to draw such a conclusion."

He says it's not possible to know from the data if the bankruptcies were driven by medical debt or other costs such as mortgages, car payments, clothing or entertainment.

Dranove criticized Woolhandler et al.'s 2005 study and was paid $5,000 by the industry group America's Health Insurance Plans for his research.

Woolhandler conceded that they didn't have detailed information on households' other spending habits, but stated that, "The average value of their home was not very high, so it didn't appear that they overspent on their home."

In bankruptcies involving medical factors, the average home value was $141,861, the study said.

The average out-of-pocket medical expense for such households was $17,943 while the mean household net worth for "medical bankrupt" households was -$44,622, the study shows.

But, it was not possible to determine medical costs' share of total household debt because the study did not report debt.

Medical bills at the time of bankruptcy may overstate their importance. People tend to put such bills on credit cards. It's standard practice for heavily indebted people to pay their mortgage, but not their credit card balances, because bankruptcy typically wipes out such unsecured debt.

The authors stressed that health-related bankruptcy filers were middle class. But the study's data showed such households' median annual income was just $26,700, not far above the poverty line.

Also, 2007 was the peak of the last economic expansion, so you'd expect to see fewer bankruptcies from a lost job or other business cycle reason than in 2001, when the U.S. was in recession.

Misdiagnosis?

Dranove also contends that one can't know from the study the number of households that would have gone bankrupt even without medical expenses, thereby obscuring the true scope of the problem.

"Suppose someone without health care spending went bankrupt in August, but with health care expenses goes bankrupt, in June," he said. "Yet that's counted as a medical bankruptcy in their study."

Also, it may be the illness, not the bills, that pushes people over the financial edge.

"In many cases where the person gets sick and can't work, it's not the medical bills that are the problem, but rather the person couldn't work," added Gail Heriot, a professor of law at the University of San Diego.

In 25% of the study's "medical" bankruptcy cases, neither spouse was working.

"That's kind of a 'what if' question that's not possible to answer because we can't subtract the medical problems these people have," Woolhandler said.

The study noted that when people lose their job due to illness, they often lose their health insurance, leaving them vulnerable.

Dranove says new research he's conducted shows that those with insurance don't have much problem with medical bills but those people near retirement and are uninsured can lose up to half of their savings due to illness. He says that should be a major call to action.

But he worries that this study hampers needed reform.

"Their methods are giving cover to individuals who will not accept that our health insurance system is broken," he said. "It allows academics who are in favor of the status quo to say that the research in favor of change is bogus."

"These articles have been published in top journals and subjected to detailed peer review," Woolhandler responded. "I think what's going on here is that the credit industry and insurance industry don't like the result."

The American – The Journal of the American Enterprise Institute

The Medical Bankruptcy Myth

By Brett J. Skinner

Wednesday, August 19, 2009

Filed under: Health & Medicine, Economic Policy, Government & Politics, Numbers

There is no evidence to indicate that a government-run healthcare system in the United States will reduce personal bankruptcies.

The debate about American healthcare is being influenced by recent controversial research claiming to show that nearly two-thirds of personal bankruptcies in the United States resulted from uninsured medical expenses or loss of income due to illness. An earlier 2005 edition of this research claimed that just over half of personal bankruptcies were due to these "medical causes." The authors of these studies, David Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, argue that the problem of "medical bankruptcies" would be solved by the adoption of a government-run health insurance system like Canada's.

The research has been politically persuasive. President Obama himself cited the dubious link between medical expenses and personal bankruptcy as part of his rationale for a massive increase of government involvement in healthcare. "The cost of healthcare now causes a bankruptcy in America every 30 seconds," he declared in March. "By the end of the year, it could cause 1.5 million Americans to lose their homes."

A July 28 hearing of the House Judiciary Committee titled, "Is Our Healthcare System Bankrupting Americans?" prominently featured the medical bankruptcy study. More recently, in a USA Today column, Speaker of the House Nancy Pelosi and House Majority Leader Steny Hoyer cited medical bankruptcy to justify their healthcare overhaul efforts.

The idea that large numbers of Americans are declaring bankruptcy due to medical expenses is a myth.Yet the medical bankruptcy study has been soundly refuted by several researchers. This

includes critiques published by David Dranove and Michael Millenson in Health Affairs and a working paper by the American Enterprise Institute's Aparna Mathur. The idea that large numbers of Americans are declaring bankruptcy due to medical expenses is a myth.

Dranove and Millenson critically analyzed the data from the 2005 edition of the medical bankruptcy study. They found that medical spending was a contributing factor in only 17 percent of U.S. bankruptcies. They also reviewed other research, including studies by the Department of Justice, finding that medical debts accounted for only 12 percent to 13 percent of the total debts among American bankruptcy filers who cited medical debt as one of their reasons for bankruptcy.

As for the notion that greater government involvement in health insurance will reduce bankruptcy, it is helpful to compare personal bankruptcy rates in the United States and Canada. Unlike the United States, Canada has a universal, government-run health insurance system. Following the logic of Himmelstein and colleagues, we should therefore expect to observe a lower rate of personal bankruptcy in Canada compared to the United States.

Research on both sides of the border shows that the majority of debt among bankrupt consumers in both Canada and the United States is composed of non-medical expenditures and therefore has little to do with health insurance coverage. Yet the evidence shows that in the only comparable years, personal bankruptcy rates were actually higher in Canada. Personal bankruptcy filings as a percentage of the population were 0.20 percent in the United States during 2006 and 0.27 percent in 2007. In Canada, the numbers are 0.30 percent in both 2006 and 2007. The data are from government sources and defined in similar ways for both countries and cover the time period after the legal reforms to U.S. bankruptcy laws in 2005 and before the onset of the 2008 economic recession.

This is important, because the 2005 reforms produced U.S. legal standards for bankruptcy filing that are now very similar to Canada's. Before 2005 it was much easier to file for bankruptcy in the United States, making cross-border comparisons prior to the legal changes meaningless. Further, in 2008 the United States was harmed by massive systemic home mortgage defaults that did not occur in Canada because of differences in mortgage lending practices. U.S. mortgage defaults would have been correlated with increased bankruptcy rates. Therefore, Canada-U.S. comparisons in 2008 are not valid because the data is skewed by other policy differences unrelated to health insurance.

Aside from universal single-payer health insurance, there are few other significant health, social, or legal policy differences between the two countries that could be causally linked to bankruptcy rates. Both countries have employment insurance programs that provide income support in the event of job loss. In fact, unemployment occurs with roughly similar frequency among Canadians and Americans. National unemployment rates in 2007 were 5.3 percent in Canada versus 4.6 percent in the United States.

Researchers found that medical spending was a contributing factor in only 17 percent of U.S. bankruptcies.Drug insurance is also structured almost identically, so exposure to drug costs is similar in both countries. While the entire Canadian population is universally eligible for publicly funded insurance for hospital and physician services, only about one-third of the Canadian population is publicly insured for prescription drugs. In Canada, as in the United States, low-income people, disabled populations, and seniors are eligible for separate publicly funded drug programs, while most employed people obtain drug insurance as a benefit of employment, and the rest of the population pays cash.

Access to medical care for people who experience long-term unemployment, disability from illness, and chronic low-income status is also practically the same in both countries, being facilitated by non-profit, publicly funded community health centers and public programs such as Medicaid in the United States and government-run systems in Canada.

The truth is that the majority of debt among bankrupt consumers in both Canada and the United States is comprised of non-medical expenditures and therefore has little to do with health insurance coverage.

On the rare occasion that medical debts do partially contribute to bankruptcy, they likely accumulate from patients' demands for the kinds of expensive, cutting-edge or end-of-life treatments that would never be covered by government insurance anyway. It is a fact that many of these same types of expensive treatments are increasingly not insured by government healthcare in Canada.

Indeed, if we define medical bankruptcies the way Himmelstein and colleagues did for their study in the United States, we find such bankruptcies also occur in Canada. Survey research

commissioned by the Canadian government found that despite having a government-run health system, medical reasons (including uninsured expenses), were cited as the primary cause of bankruptcy by approximately 15 percent of bankrupt Canadian seniors (55 years of age and older).

There is no objective evidence to indicate that a government-run health care system in the United States will reduce personal bankruptcies. The U.S.-Canada comparative analysis strongly suggests that bankruptcy statistics are being exaggerated and distorted for political reasons.

Brett J. Skinner is director of bio-pharma, health, and insurance policy at the Fraser Institute and is the primary author of a recently published study, "Health Insurance and Bankruptcy Rates in Canada and the United States." He lives in Toronto.

Image by Darren Wamboldt/The Bergman Group.

Statement before the United States Senate
Committee on the Judiciary
Subcommittee on Administrative Oversight and the Courts
Hearing on "Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?"

Aparna Mathur

Research Fellow and Jacobs Associate

American Enterprise Institute

Tuesday, October 20, 2009

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman and Distinguished Members;

Thank you for inviting me to testify before the Committee on the issue of medical debts and bankruptcy reform. In my testimony today, I will explore the role that the current bankruptcy code plays in the lives of medical debtors as well as the proposed reforms in the Medical Bankruptcy Fairness Act (2009) designed to better address such concerns. This is an issue of tremendous importance not only for American families battling illnesses and injuries, but for policymakers as they attempt to reform the healthcare system to provide affordable and efficient care to patients.

The urgency to tackle the issue of medical bankruptcies is being largely driven by studies claiming that more than 60 percent of all personal bankruptcy filings are caused by medical debt. I hope that through my testimony I will be able to dispel the belief that medical bankruptcies are such a large fraction of all bankruptcies today. However, whatever the extent of the problem, anecdotal evidence of the hardship suffered by families struggling with medical bills and loss of jobs is hard to ignore. The question we are concerned with today is whether a reform of the bankruptcy code, as put forward in the Medical Bankruptcy Fairness Act, would provide a solution to the problem of medical bankruptcies. Do medical debtors need to be treated differently within the bankruptcy code than say debtors with credit card debts or mortgages? While I believe that the sentiments underlying the Act are understandable, during the course of my testimony I will attempt to show that the provisions of the Act may be open to abuse and fraud. This could have unintended adverse consequences for debtors that may worsen rather than improve the functioning of the bankruptcy system.

My testimony will first focus on whether evidence supports the essential premise underlying the introduction of the Medical Bills Fairness Act which appears to be the much

debated surge in medical bankruptcies in recent times. Second, it will explain how the bankruptcy code currently affects medical debtors. Third, it will provide details on the proposed reform and its practical applicability. Finally, it will explore the possible abuse of the Act based on a literature review of the effect of bankruptcy laws on debtor behavior.

I. Medical Debts and Bankruptcies

The Medical Bankruptcy Fairness Act is intended as a solution to the problem of rising medical bankruptcies. While I applaud the goals underlying the Act, I also believe that it results from a mis-diagnosis of the problem. The essential premise of the Medical Bankruptcy Fairness Act of 2009 is that today medical debts are the leading cause of consumer bankruptcy filings in the U.S. and therefore medical debts need to be addressed differently from other debts. How valid is this supposition?

The American Bankruptcy Institute provides statistics on consumer bankruptcy filings for the U.S. since 1980.[1] The data show a rise in filings from about 1.2 million in 2000 to 2.0 million in 2005. In 2006, filings dipped to 597,000 presumably due to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 which instituted a means-test provision by which only low income filers could file for bankruptcy and discharge their (unsecured) debts. In 2008, bankruptcy filings have again crossed a million. What fraction of this is due to medical debts?

Data on medical debts is available from the Survey of Consumer Finances (SCF).[2] The SCF survey samples approximately 4500 households every three years to assess families' financial situations and provides a picture of their debt and asset levels. The households are

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[1] http://www.abiworld.org/AM/AMTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=57826

[2] http://www.federalreserve.gov/pubs/oss/oss2/scfindex.html

randomly selected to avoid biased results. A look at the latest SCF data (2007) shows that medical indebtedness has not changed significantly over the past decade or so. The SCF includes medical debts with other debts incurred for "goods and services", including credit card debt. These debts have risen marginally from 5.5 percent of all debt in 2001 to 5.8 percent in 2007.[3] The SCF shows that this change is mainly being driven by rising credit card debts where the average value has increased from $4800 to $7300 (Medical debts are excluded from the credit card debt category). Since there is no significant change in the proportion of medical debt as a fraction of all debt, it is hard to conclude that medical debts are responsible for an increasingly large fraction of bankruptcy filings. A paper by Bucks (2008) analyzing the SCF data for 1989-2004 shows, in fact, that the number of families reporting any medical debt has declined from 3.6 percent in 2001 to 2.8 percent in 2004. [4] The same paper also shows that medical debts as a fraction of all debts have remained steady at 0.3 percent between 2001 and 2004.[5]

The literature on bankruptcies and medical debts can methodologically be divided into two streams, one that has focused on survey data and the other on empirical regression analysis. For instance, relying on surveys of 1032 bankruptcy filers, Himmelstein et al. (2009) conclude that approximately 62 percent of all bankruptcies in 2007 were "medical."[6] Their earlier study (Himmelstein et al. (2005)), based on a 2001 survey of 1000 filers, concluded that approximately 46 percent of all bankruptcies had medical causes.[7] Note that in both studies, "medical" refers to all sorts of medical reasons for a bankruptcy filing, not just medical debts. These include lost

[3] The largest categories of debt are mortgages and vehicle loans.
[4] http://www.iariw.org/papers/2008/bucks.pdf
[5] Data for 2007 are not available from the paper.
[6] Himmelstein, David, Warren, Elizabeth, Thorne, Deborah and Woolhandler, Steffie (2009), "Medical Bankruptcy in the United States, 2007: Results of a National Study", The American Journal of Medicine, available at: http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf
[7] Himmelstein, David, Warren, Elizabeth, Thorne, Deborah and Woolhandler, Steffie (2005), "Illness and Injury as Contributors to Bankruptcy", *Health Affairs* (Web Exclusive), 2 February

weeks of work due to own illness or spouse's illness, as well as when the debtor said that a medical problem of a family member caused the bankruptcy filing. The idea that medical bankruptcies are on the rise comes essentially from these two studies. In the Appendix to this testimony I discuss methodological problems with these studies that may lead to biased results. However, even if we take their estimates at face value to calculate the fraction of medical bankruptcies in total bankruptcies, the number of medical bankruptcies has in fact declined from 667,933 (46 percent of 1,452,030) in 2001 to 510,005 (62 percent of 822,590) in 2007. Hence there is little to suggest that there has been a surge in medical bankruptcies that warrants a big change in the bankruptcy code.

Most other studies in fact suggest a minimal role for medical debts in bankruptcy. The closest comparable survey to the Himmelstein et al. studies is a study of bankruptcy filers by the Department of Justice's Executive Office of the United States Trustee (USTP). 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 of filers reported medical debts less than $5,000.

A more nationally representative survey is the Panel Study of Income Dynamics (PSID), which is a longitudinal survey tracking households since 1968.[8] In 1996, the PSID asked respondents whether they had ever filed for bankruptcy between 1996 and 1984, and if so, what were the primary, secondary and tertiary reasons for filing from a given a list of possible reasons, which included medical bills, job loss, injury or illness, etc. This is the most definitive survey so

[8] http://psidonline.isr.umich.edu/

far in terms of determining the proximate cause of a bankruptcy filing. The largest contributor to bankruptcy filings was high credit card debt. Nearly 42 percent of respondents reported high credit card bills as the primary reason for filing, while an additional 9 percent claimed it as the secondary reason for filing. Other big reasons were job loss (13 percent) and divorce or separation from spouse (12 percent). Only 9 percent of the sample claimed medical bills as the primary reason for filing, and 7 percent claimed it as a secondary reason.

By their very nature, survey data are unable to account for a host of other factors that might help explain why households file for bankruptcy. For instance, factors like average household wealth and income, state-level factors such as bankruptcy exemptions and unemployment rates, and household expenditures such as rent and taxes could each play a significant role in a household's decision to file for bankruptcy. The standard methodology in the economics literature for accounting for all of these factors is multivariate regression analysis. With regression analysis, it is possible to study the effect that each factor has on the probability of filing for bankruptcy while holding the effect of all other variables constant. This is the only way that one can establish causation, rather than correlation. In other words, only when we use regression analysis to control for the effect that each of the other factors has on a bankruptcy filing can we be sure that medical debts *cause* bankruptcy filings.

A 1999 study by Ian Domowitz and Robert Sartain in the *Journal of Finance* uses exactly this approach. The authors examined 827 households who filed for bankruptcy in 1980 matched against 1,862 households not in bankruptcy. Accounting for prevalence of various sources of debt, Domowitz and Sartain found that "the largest single contribution to bankruptcy at the margin is credit card debt."

In an AEI Working paper that I wrote, I estimated a model of the household bankruptcy filing decision, using PSID data for the period 1994-1996 and a three year panel covering the years 1984, 1989 and 1994 respectively.[9] The main aim in the paper was to test whether medical debts can be ascribed as the leading cause of bankruptcy filings. The results from my paper do not support the view that medical debts are the *leading* cause of bankruptcy filings. In fact, households who are most likely to file are those with *primarily* other forms of debt, such as credit card or car debts, who *also* incur medical debts. From my estimates, it appears that a 10 percent increase in medical debts, as occurred over the period 2001-2007, could account for a 27 percent increase in bankruptcy filings over the same period, among filers with predominantly medical debts.

To summarize this section, there is little in the literature to suggest that medical bankruptcies account for more than 50 percent of all bankruptcies. Therefore, if that is the essential premise of the Medical Bankruptcy Fairness Act, then the foundations of the Act are built on shaky grounds.

II. Current Bankruptcy Code and Proposed Reforms

How does current bankruptcy law affect medical debtors? Under current law, debts incurred for medical treatments are completely dischargeable under Chapter 7 of the bankruptcy code. This includes services provided by doctors, hospitals, dentists, chiropractors, physical therapists and other medical providers. In addition to medical debts, Chapter 7 also eliminates other unsecured debts such as credit card debts and personal loans. Therefore individuals who have piled up high medical debts on their credit cards can get that debt discharged as well. The

[9] "Mathur, Aparna (2006), "Medical Bills and Bankruptcy Filings," AEI Working Paper http://www.aei.org/paper/24680

advantage of a Chapter 7 bankruptcy is that debtors can retain some or all of their property and shield it from being used to repay creditors at the time of a bankruptcy filing. The value of assets that they can protect depends upon the exemption level in the state of filing. Exemption levels can range from a few thousand dollars to more than $100,000.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 instituted a means-test provision by which only filers with incomes below the median income in their state could file for bankruptcy and discharge their (unsecured) debts under Chapter 7. All other filers have to file under Chapter 13. This enables individuals to pay back medical debts and other unsecured debts over a three- to five-year period, without additional interest or penalty fees. In most cases, the payments will be based upon what the individuals can afford, rather than what they owe.

Therefore, even under the current system, medical debtors can get relief from their debts by filing for bankruptcy either under Chapter 7 or Chapter 13 since this is unsecured debt.

The Medical Bankruptcy Fairness Act of 2009 will reform the current system in the following ways. First, the Act would amend Section 101 of the Bankruptcy Code, which is more commonly known as the definitions section. Section 101 would be amended to add the definition of a "medically distressed debtor" as a debtor, or a dependent of the debtor, who has in excess of the lesser of 10 percent of the household income or $10,000.00 of medical debt (which was not covered by insurance) in a twelve month period in the last three years or lives in a household with a person who was out of work for four weeks in the last twelve months due to medical reasons.

Second, it would allow these medically distressed individuals to claim an exemption against their home of $250,000. This would override any state homestead exemptions that would typically vary from a low value of $5000 to more than $100,000.

Third, it would remove the requirement for medical debtors to undergo credit counseling prior to filing for bankruptcy.

Finally, it would also remove the means-testing requirement for medically distressed debtors. In other words, all individuals defined as being medically distressed debtors could file under Chapter 7, even if their mean income was above the median income in their state.

While the purpose of the Act is to make the bankruptcy process easier and more efficient for medical debtors, there are several unintended consequences and problems with the proposed reforms to the bankruptcy code that I outline below.

(1) Definition of medically distressed debtor

The definition of a medically distressed debtor is open to abuse and fraud. By definition, a medically distressed debtor is anyone who incurred debts of the lesser of $10,000 or 10 percent of income at any time within a twelve month period in the three years prior to the filing. To see what this implies for the actual level of medical debts, it is helpful to look at a typical distribution of bankruptcy filers by income level. A study of the distribution of bankruptcy filers by income in 2000-2002 showed that more than 85 percent of filers had annual incomes less than or equal to $48,000, with almost 60 percent earning between $24,000-$36,000.[10] This means that

[10] Marianne B. Culhane & Michaela M. White, *Taking the New Consumer Bankruptcy Model for a Test Drive: Means-Testing Real Chapter 7 Debtors*, 7 AM. BANKR. INST. L. REV. 27, 37–38 (1999); Ed Flynn & Gordon Bermant, *Bankruptcy by the Numbers: Chapter 7 Asset Cases*, AM. BANKR. INST. J., Dec. 2002–Jan. 2003

if the average filer spent about $2400-$4000 on medicines or medical care in any year, then they would qualify for a medical bankruptcy. This seems like a relatively low level of debt considering that the same study shows that credit card debts average approximately $20,000 for this group of low-income borrowers. In the worst case scenario, this could create perverse incentives for households since by accumulating a relatively lower level of medical debt, they could take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of their high credit card debts. In fact, it might even tempt households to accumulate other types of debt prior to the filing, since they are eligible for debt discharge under Chapter 7. Therefore, by allowing debtors to file as medical debtors irrespective of whether medical debts are actually driving the household to bankruptcy, the Medical Bankruptcy Fairness Act would essentially be providing relief from credit card debt rather than medical debts.[11]

A second problem with this definition is that it imposes huge informational requirements for a bankruptcy filing. For an attorney to establish a debtor as a medically distressed debtor, they would have to go back three years in either their, or one of their dependent's, medical history and determine that at any one time during that three year period, was there a specific time when the debtor or one of their dependents had more than $10,000.00 outstanding in medical debt which was confined to a twelve month period. Then, they would have to determine whether the debtor had insurance, and what bills, if any, were either paid by insurance or not. It is extremely hard to imagine that debtors would be able to provide such detailed medical bills for themselves as well as their family, along with all the insurance documentation.

(2) No Means Testing

[11] http://weber.ucsd.edu/~miwhite/UIll-law-review--final.pdf

The means test incorporated into the bankruptcy code in 2005 was designed to limit the use of Chapter 7 bankruptcy to those who truly cannot pay their debts. In effect, it limits the ability of high income filers to walk away from their debts when they have the ability to pay for them by forcing them into Chapter 13 bankruptcy. This increases efficiency and ensures that creditors get at least a minimum return on their debt. Doing away with the means test under the Medical Bankruptcy Fairness Act would allow high income individuals to walk away from not only their medical debts, but also other debts such as credit card debts. For instance, it is typically the case that families incurring high medical debts, especially due to job loss or other adverse events, also incur other debts, such as car loans, unpaid utility bills, credit card debts etc. If medical filers are no longer subject to means testing, then high income debtors would have an easier time walking away from their other dischargeable debts. In the study of bankruptcy filers cited earlier, those with incomes higher than $70,000 had average credit card debts of $42,000. Allowing this group to take advantage of the debt discharge provisions under Chapter 7 would hit creditors particularly hard. This is the exact situation that the 2005 bankruptcy reform tried to address. One possibility to avoid such a situation could be to set higher percentage of income thresholds for medical debt for higher income households, to allow eligibility for a Chapter 7 bankruptcy.

(3) Effect on Creditors

The Act does little, if anything at all, for the creditors in these medical transactions. As discussed in the previous two paragraphs, there could be potentially serious consequences for medical service providers if we make it easier for debtors to file for medical bankruptcy involving the discharge of all medical debts. In fact, research has shown that between 1994 and 2000, unsecured creditors received nothing in about 96 percent of Chapter 7 bankruptcy filings,

and in most Chapter 13 cases, only mortgage creditors received anything at all.[12] These higher costs of bad debts will ultimately be passed on to consumers in the form of higher prices for care or poor delivery of care.

(4) Exemption Limits Raised

There is now a fairly large volume of economics papers that discusses how high bankruptcy exemptions affect debtor behavior. Debtors value high exemptions because it provides them with consumption insurance by discharging some or all of their debts when a drop in income would otherwise have caused a drop in consumption. However, because higher exemptions for wealth and income make filing for bankruptcy more attractive, studies show that the number of filings increases when exemptions increase.[13] This adversely affects the market for credit. To insure against the probability of a bankruptcy filing, lenders raise interest rates or ration credit,[14] which harms debtors who repay as well as those who would like to borrow but are rejected.[15] Hence creditors alter behavior when faced with higher exemptions.

At the same time, the incentive for debtors under these high exemption limits is to reallocate all wealth from non-exempt assets to exempt assets. For instance, if the homestead exemption were raised to $250,000 the individual would have an incentive to convert all non-housing assets

[12] Stewart E. Sterk, *Asset Protection Trusts: Trust Law's Race to the Bottom?*, 85 CORNELL L. REV. 1035, 1036 (2000).

[13] Michelle J. White, *Personal Bankruptcy Under the 1978 Bankruptcy Code: An Economic Analysis*, 63 IND. L.J. 1, 45–46 (1987) (discussing data indicating that an increase in the bankruptcy exemption level corresponds with an increased bankruptcy filing rate).

[14] Reint Gropp, John Karl Scholz, & Michelle J. White, *Personal Bankruptcy and Credit Supply and Demand*, 112 Q.J. ECON. 217 (1997) (showing that higher exemption levels result in higher interest rates).

[15] The optimal exemption levels in bankruptcy are determined by trading off debtors' gain from having additional consumption insurance and better work incentives when exemption levels are higher against their losses from higher interest rates and reduced access to credit. For a formal model and simulations, see Michelle J. White, Personal Bankruptcy: Insurance, Work Effort, Opportunism and the Efficiency of the "Fresh Start," (May 2005) (unpublished manuscript, on file with author), *available at* http://www.econ.ucsd.edu/~miwhite/bankruptcy-theory-white.pdf, and Hung-Jen Wang & Michelle J. White, *An Optimal Personal Bankruptcy Procedure and Proposed Reforms*, 29 J. LEGAL STUD. 255, 265 (2000).

to housing (say by using all available bank accounts to pay off the mortgage), so as to protect more of their income and wealth from the creditors. Therefore, there are both costs and benefits to having higher exemption limits that need to be recognized.

To summarize this section, what the Medical Bankruptcy Fairness Act would do is make the financial benefit from filing for a *medical* bankruptcy higher than the financial benefit of filing for any other type of bankruptcy. The higher exemption levels, the lack of means testing and credit counseling and the potential to identify oneself as a medical debtor would clearly lead to strategic behavior on the part of some opportunistic debtors. Medically distressed debtors who are able to file under Chapter 7 would use this to get rid of their credit card debts. This would be especially advantageous for high income debtors who are unable to file for Chapter 7 bankruptcy under the current code. This large scale discharge of credit card debts, available even to debtors with the ability to repay some of their debts, is one aspect of the previous bankruptcy code that the 2005 reform sought to undo. We need to understand therefore, that the changes being considered under the Medical Bankruptcy Fairness Act could impose tremendous costs on the system while conferring benefits to a few.

III. Conclusion

To summarize, the case for bankruptcy reform to help medically distressed debtors is built on somewhat shaky foundations. While the intentions are laudable, there is little to support such an intervention based purely on the incidence of medical debts in bankruptcy filings. Despite some recent survey evidence suggesting that medical debts account for more than 60 percent of all filings, more rigorous analysis finds a relatively smaller proportion of bankruptcies that can be attributed to medical debts.

Further, the Medical Bankruptcy Fairness Act could create perverse incentives for debtors to accumulate non-medical debts prior to a filing, as long as they can file as medically distressed debtors. The Act attempts to overturn several features of the bankruptcy reform enacted in 2005 by doing away with a means test for medical debtors and allowing medical debtors to claim a homestead exemption higher than that allowed under the current code in several states. This could have adverse consequences on at least two fronts. One, high income filers with the ability to repay their debts can get complete debt relief under Chapter 7, while imposing losses on their creditors. Two, the high homestead exemptions could affect credit markets by causing creditors to raise the interest rate on loans provided and/or ration credit. In other words, the proposed reform could have unintended adverse consequences for debtors as well.

I believe that any situation that causes a household to file for bankruptcy is unfortunate. In these tough economic times, individuals who lose their job for no fault of theirs are as badly affected as families hit by illnesses or injuries. Individuals who lose their homes because of a painful divorce are no worse off than people who are unable to pay their mortgages due to an unexpected change in credit conditions. Where do we draw the line for who we want to help and who we don't? The most effective solution to the problem of rising bankruptcies is to create the right conditions for an economic recovery, so that families can hold on to their jobs, retain their earning power, stay in their homes, and live within their means. We should help them to avoid bankruptcy rather than make it easier to file it.

Appendix

Problems with the Himmelstein et al. (2005 and 2009) Studies

(1) Sample Selection Issues

A major shortcoming with both the Himmelstein et al. (2005 and 2009) studies is what economists dub the "sample selection issue". Himmelstein et al. (2005, 2009) conducted a survey of bankruptcy filers from public court records for the year 2001 and 2007. Based on a sample of 1000 debtors, they concluded that more than 50 percent of these had filed for bankruptcy due to a medical reason. By limiting the sample to those who had already filed for bankruptcy, the study overstated the incidence of medical debt. To account for causation, the study sample should have, at the very least, included a "control" group of medical debtors who did not file for bankruptcy. In other words, if the authors were trying to establish whether medical debts *cause* bankruptcy filings, the appropriate sample should have included households with and without medical debt, and households who filed or did not file for bankruptcy. In short, what the authors have established is some correlation, but not causation.

The sample also seems skewed towards debtors with high medical debt. The USTP report of bankruptcy filers, which included a much larger sample of 5203 filers, found that 90 percent of filers had medical debts less than $5000. The Himmelstein et al.(2009) study reports nearly 35 percent of filers with more than $5000 in medical debt. The authors make no attempt to reconcile or explain their findings or reveal the distribution of medical debts across filers in their sample.

(2) Regression Analysis

The study also should have allowed for the possibility that other household characteristics, such as the filer's work status, marital status, income, and other kinds of debts

could have influenced the filing. As explained earlier, this could be done through the use of appropriate regression techniques applied on a suitably large, random sample of filers and non-filers. Mainstream economics literature discussing the relationship between debts and bankruptcy amply outlines these standard considerations. The study does claim to have done multivariate analysis, but the analysis is done on an even more restricted sample than the original 1032 in 2007. The sample only includes people who reported having any medical bills. Therefore, it simply assumes that medical debts are important for bankruptcy filing, rather than testing for that hypothesis in the entire sample of bankruptcy filers.

(3) *Definition of Medical Bankruptcy*

The 2005 study used an overly broad definition of "medical filers," which included people with any sort of addiction or uncontrolled gambling problems. The 2009 study removed these clauses but still came up with a 62 percent number i.e nearly 62 percent of bankruptcy filings are due to medical reasons. The reason for the high number is puzzling, though as mentioned earlier, it is partly driven by the fact that the authors ascribe any remotely medical factor as causing the bankruptcy filing, not just medical debts. The survey results shown in Table 2 (Page 3) of the study clearly state that only *29* percent of the respondents believed that their bankruptcy was actually *caused* by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than $5000 in medical bills, and the percent of people reporting any medical problems. This is clearly an overstatement of the problem. Since the respondents themselves do not believe that these other factors caused the bankruptcy filing, it is wrong to ascribe the additional bankruptcy filings to their medical costs. A related point is that the survey fails to provide information on other causes of the bankruptcy filing or how the respondents would rank different

factors, as in the PSID. Therefore, it is unclear whether medical bills were the most important cause or just another cause.

This criticism was also raised by Dranove and Millenson in reference to the 2005 paper.[16] Exhibit 2 of that paper identified people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, Dranove and Millenson conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, it cannot be stated with any degree of certainty whether medical spending was the most important cause of bankruptcy.

[16] Dranove, David and Millenson, Michael, L. (2006), "Medical Bankruptcy: Myth vs Fact" HEALTH AFFAIRS 74 (2006)

Medical Bills and Bankruptcy Filings

Aparna Mathur[1]

Abstract

Using PSID data, we estimate the extent to which consumer bankruptcy filings are induced by high levels of medical debt. Our results suggest that nearly 27 percent of filings are a consequence of *primarily* medical debt, while in approximately 36 percent of cases medical debts co-exist with primarily credit card debts. Studying the post-bankruptcy scenario, we find that filers are 19 percent less likely to own a home even several years after the filing, compared to non-filers. However, the consequences are less adverse for medical filers i.e those who filed due to high medical bills compared to other filers.

JEL Classification: D6, K3, C33

Keywords: Personal Bankruptcy, Medical Debts, Probit Model

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I. Introduction

In the 1990s, consumer bankruptcy filings as a percentage of total filings have been steadily increasing. In 1990, the number of filings was approximately 718,000 (92 percent of all filings), which doubled in 2004 to 1.6 million filings (accounting for 98 percent). What accounts for the "boom" in consumer bankruptcy? In the literature, there are two views about consumer bankruptcy filings. Rising household debt with increasing use of credit cards and rising mortgage payments which lead to accumulation of high-interest debt has been cited as an important explanatory factor. Some studies also suggest that sudden shocks to income in a situation of high consumer indebtedness may provoke a bankruptcy filing. Sullivan et al (1989) conclude that the primary cause of bankruptcy filings in their sample was unemployment or employment interruptions. A divorce, also, may create an unexpected shock to household income or reduce the economies of scale from living in a single household.

Second, the strategic view of bankruptcy advocates is that households file for bankruptcy because the financial benefit from filing has gone up. Under Chapter 7 personal bankruptcy, debtors in the US can retain some or all of their property from being used to repay creditors at the time of a bankruptcy filing. The amount of assets that they can protect depends upon the exemption level in the state of filing. Since the Federal Bankruptcy Code of 1978, every state in the US has been allowed to set its own property and homestead exemption levels.[1] Recently newspapers reported a surge in bankruptcy filings in anticipation of a change in the Personal Bankruptcy law, which would make it harder for households above a certain median income to file for Chapter 7 bankruptcy, and also placed a cap on the maximum exemption limit.[2] This seems to support the

strategic view of bankruptcy since it seemed that households were filing to take advantage of the higher exemptions associated with the older, more lenient system. Fay et al (2002) find support for this view which predicts that households are more likely to file when their financial benefit from filing is higher.[3] They use PSID data for the period 1983-1996 and find the coefficient on Financial Benefit to be positive and statistically significant. An increase of $1000 in households' financial benefit from bankruptcy is associated with a 7 percent increase in the probability of filing. On the other hand, health problems faced by the household head or spouse, spells of unemployment, and the household head being divorced in the previous year are positively related to bankruptcy filings, but not significant. Related to this view, Gross and Souleles (2002) used a dataset of individual credit card accounts to explain account holders' bankruptcy decisions. Their main explanatory variable is lenders' rating of individual account holders' riskiness and their main finding is that after controlling for increase in the average borrower's riskiness, the probability of default rose significantly between 1995 and 1997. They interpret this result as evidence that the stigma associated with bankruptcy has fallen.

This paper asks the question whether increasing health care costs are leading to a rising number of consumer bankruptcies, and if so, to what extent. The empirical evidence to this effect is contradictory. Studies based on surveys of bankruptcy filers, such as Himmelstein et al. (2005) using data from the Consumer Bankruptcy Project, claim that families with medical problems and medical debts account for nearly half of all bankruptcy filings.[4] However, their classification of a medical bankruptcy is too broad.[5] A big drawback of the study is that it does not include non-filers in the sample. This is a problem because there may be non-filers who experienced similar problems but did not

file for bankruptcy. Thus the sample lacks an effective control group. According to another survey, the *Health Care Costs Survey* (KFF, 2005), close to 23 percent of Americans had problems paying medical bills in the previous year.[6] Around 19 percent experienced other financial consequences due to medical bills, such as having to borrow money, being contacted by a collection agency, or even having to file for bankruptcy. Another study based on the Commonwealth Fund Biennial Health Insurance Survey (2005) reveals that an estimated 77 million (37 percent) Americans aged 19 and older have difficulty paying medical bills, have accrued medical debt or both.[7] Domowitz and Sartain (1999) find that "high" medical debt also contributes positively to bankruptcy, though credit card debt is the single largest contributor to bankruptcy filings at the margin. Medical debt is included in a binary form with a positive value indicating expenses in excess of 2 percent of income. This classification is arbitrary.[8] Further, the study is based on cross-sectional data and does not have demographic information. Thus it is unable to account for dynamic changes in household or state level conditions such as state incomes, unemployment rates etc.

The Office for United States Trustees (in the US Department of Justice), on the other hand, found that medical debt was not a major factor in the majority of bankruptcy cases filed in 2000.[9] More than 50 percent of filers reported no medical debt at all, while only 11 percent had medical debt in excess of $5000. Further, only in 5 percent of the cases was medical debt one-half or more of total unsecured debt. On average, medical debt was only about 6 percent of all unsecured debt. In comparison, credit card debt comprised about 40 percent of all unsecured debt. More than half the cases reported credit card debt in excess of 50 percent of all debt.

The contention in our paper is that while medical care costs are rising and are important in explaining bankruptcy filings, the economic impact is not as large as is being reported. In our dataset, we find that up to 27 percent (depending on the sample period) of all filings involve cases where medical bills were the *primary* form of debt. If we include all cases where there was *any* mention of medical debts, the number goes up (at most) to 36 percent. This percentage is on the high side since it includes those with primarily credit card, mortgage or car debt, who *also* accumulate medical debt. These numbers are significantly lower than the 50 percent claimed by Himmelstein et al (2005). They are closer to the 30 percent claimed by Domowitz and Sartain (2002) especially if we only consider primarily medical debt cases. We believe that a shortcoming with the earlier studies is that they are unable to isolate the impact of medical bills from other problems that the debtor faces, such as job loss, low earnings, and other credit card debts. This makes it difficult to conclude that high costs of medical care are *causing* the large number of bankruptcy filings. In this paper, we attempt to study the importance of various distinct factors, in particular other debts, such as credit card charges, that the household has incurred. 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. We use household level data from the Panel Study of Income Dynamics (PSID) to estimate the impact of illnesses and medical debts on the probability of filing for bankruptcy. This is the first paper to use longitudinal household data to identify the impact of medical bills (and other health related factors) on bankruptcy. We extend our analysis to further study the post-bankruptcy situation for individuals. Using data on home ownership and labor supply in the PSID, we conclude

that individuals who have filed for bankruptcy are significantly less likely to own homes, while they are significantly more likely to increase labor supply to accumulate savings.

Medical problems can lead to bankruptcy in a number of ways. Health problems can cause individuals to lose work days, which results in loss of earnings. Medical bills can pile up, especially if the debtor does not have health insurance. In terms of costs of health care, Zywicki (2004) reports that there is little evidence that fluctuations in the cost of health care are linked to increases or decreases in bankruptcy rates. In fact, adjusting for inflation, he finds that during the 1990s there were some periods when health care costs went up only marginally, while bankruptcy rates rose by 20-29 percent. Results are mixed even when we study health insurance rates and bankruptcy. While the percentage of Americans without insurance has remained relatively stable, bankruptcy rates have been rising over time.[10]

In this paper, we incorporate into the model both the traditional factors associated with a bankruptcy and the strategic factors such as the exemption levels across states, which affect the financial incentive to file for bankruptcy. We further attempt to control for health related factors including medical coverage. The panel nature of the data allows us to control for all the factors leading to the bankruptcy, rather than focusing only on the period around the time of the bankruptcy. Further, we include in the sample both filers and non-filers, instead of including only people who have already filed. This enables generalizations of results to the larger population as well.

In the next section, we discuss the data and explanatory variables used in the analysis. Section 3 details the empirical methodology and Section 4 presents the

empirical results. Section 5 discusses the possible adverse effects of a bankruptcy filing. Section 6 concludes.

2. Data Source and Description

2. A Data Source and Summary Statistics

The data are available from the Panel Study of Income Dynamics (PSID), which is a longitudinal dataset tracking households since 1968. The PSID survey asks questions relating to demographic conditions as well as income, assets and debts of the household. In 1996, the PSID asked respondents whether they had ever filed for bankruptcy between 1996 and 1984, and if so, in what years and which state they filed. We use two panels of three years from this dataset. The first relates to the period 1994-1996. Since the PSID is a longitudinal dataset, we include in the sample all heads of household who were in the sample all three years. Each year there are approximately 6000 household heads who are interviewed, thus the overall sample size is 18,259 household heads. The bankruptcy filing rate among PSID respondents for the period 1994-1996 is approximately 0.4 percent, which is half the average national filing rate for that period of 0.8 percent. The number of filings in our sample is 74.

A problem with the PSID dataset is that it collects information on certain variables such as family wealth, asset and debt levels only every five years. Hence as a check on our results with the 1994-1996 panel, we pooled data across the three years 1984, 1989 and 1994 and re-ran the regressions.[11] The sample for this panel is 19339 household heads.

The PSID asks a detailed set of questions on bankruptcy. These include questions on the primary, secondary and tertiary reason for filing, given a list of possible reasons,

which include medical bills, job loss, injury or illness etc. The largest contributor to bankruptcy filings was high credit card debt. Nearly 42 percent of respondents reported high credit card bills as the primary reason for filing, while an additional 9 percent claimed it as the secondary reason for filing. Other big reasons were job loss (13 percent) and divorce or separation from spouse (12 percent). Only 9 percent of the sample claimed medical bills as the primary reason for filing, and 7 percent claimed it as a secondary reason. Illness and Injury accounted for only 6 percent of the filings. These statistics by themselves suggest the extent of bias in the recent Himmelstein (2005) paper, which claims that medical reasons are the leading causes behind bankruptcy filings, accounting for 50 percent of all bankruptcy filings. Unfortunately, we are unable to use responses to reasons for filing in the regression, because it is by definition, asked only of those who had actually filed for bankruptcy.

The PSID also asks questions relating to debt levels. A drawback of the PSID dataset is that while it gives information on the total value of debt, it does not provide information on each kind of debt separately. Thus, the key innovation in the paper is to distinguish medical debtors from other kinds of debtors, in order to study the impact of medical debt on the probability of filing for bankruptcy. To do this we exploit a part of the survey that has questions relating to loans taken by the household for various purposes. The survey asks individuals whether they had ever taken loans to repay their debts, and what was the largest component of the loan i.e what was *the* most important reason for taking the loan-possible reasons include repaying credit card debts, medical bills, car debts etc. They can also list other secondary or tertiary reasons for taking the loan. This is the main variable of interest, since it allows us to distinguish medical

debtors from credit card debtors, or people who had high car or mortgage debt. Hence we can classify households as medical debtors if they listed medical debts as their primary, secondary or tertiary reason for taking a loan. We can further classify households as *primarily* medical debtors if they listed medical debts as their *primary* reason for taking the loan. This should help clarify the issue of whether medical debts are the largest component of debt for households that file, or is it mainly other forms of debt, such as credit card debt, that is primarily responsible for a large number of filings.

Other relevant variables available from the dataset relate to the health status of the individual, whether they missed any weeks of work due to illness, whether they had medical coverage, etc.

Table 1 presents sample summary statistics. In terms of demographics, about 70 percent of the population is male, and around 63 percent white. The average annual family income is $43,000, while average annual debts are $4500. The bankruptcy filing rate is 0.4 percent. To distinguish between filers and non-filers, we present separately the statistics for each group in Table 2. In the sample, around 66 percent of filers are male, and more than 60 percent are white. Close to half are married. About 47 percent had medical coverage and 10 percent had experienced unemployment spells in the previous year.[12] About 40 percent were homeowners while 15 percent owned businesses. Surprisingly, there do not appear to be systematic differences in these demographics between filers and non-filers, as shown in Column 2 of Table 2.

If we look at correlations between bankruptcy and household conditions, we found no significant correlations between bankruptcy filings and individuals with medical coverage (.013), individuals in poor health (.003) and individuals who were unemployed

(.007). All kinds of loans taken to repay debts, such as medical debts, credit card debts, mortgage payments or car loans are positively correlated with bankruptcy filings. There is also a positive, though not large correlation of .108 between those with credit card loans and those with medical loans. Further, there is a positive correlation between filings and state tax rates, state unemployment rates and state exemptions.

Figure 1 profiles the average bankruptcy filer. Graphs show that the average filer is more likely to be a white male, less than 45 years of age, unmarried and with less than 16 years of education.

2. B Explanatory Variables

We explain bankruptcy filings as a function of household debt and income levels, the proportion of debt that is medical, the bankruptcy exemption level in the households' state of residence, the other expenditures that the household has to meet such as rent or mortgage payments and whether the household faced any health problems. We are also able to control for demographic variables.

DEBT refers to all unsecured debt which includes credit card debt, medical debt, personal loans, etc. Information on this variable is available only once every five years in the PSID. For the 1994-1996 sample, we use the 1994 data on unsecured debt as the total debt. For the other panel, we do not face this problem since questions are asked in 1984, 1989 and 1994. In the regression analysis, we scale this variable by total family income to assess the impact of debt as a fraction of income. FAMILY INCOME refers to all wage and salary income earned by the household during the year. Since family income varies for each year in the sample, dividing DEBT by family income serves the purpose of introducing variation in the DEBT variable over time.

WEALTH or the sum of all assets for the household (excluding home equity) is again available only in the 1984, 1989 and 1994 supplements. To this we add the house value, which varies every year, to construct the variable that is used in the analysis.

MEDICAL refers to all households who reported taking a loan to repay medical debts.[13] MEDICAL1 refers to those who reported medical debts as the primary reason for taking a loan. This is interacted with DEBT, giving us the variable MEDDEBT, to isolate the effect of medical debt on bankruptcy. MEDDEBT1 is the subset of people within MEDDEBT who reported medical debts as their most important reason for taking a loan. Thus, MEDDEBT1 includes only those who reported medical debts as their *primary* reason for taking a loan while MEDDEBT includes anybody who reported medical debt as a reason-whether primary, secondary, or tertiary-for taking a loan.[14] Table 2A and Figure 2 track changes in the number of medical debtors, and the number of bankruptcies over time. As Figure 2 shows, there is co-movement of bankruptcy filings and medical debtors, and also individuals reporting poor health. This is particularly true for the period 1994-1996.

MEDCOVER is a dummy variable equal to 1 if the household had health insurance coverage. The questions on health insurance coverage in the PSID are not comprehensive. The question asks whether the family is covered by Medicare, Medi-Cal, Medical Assistance, etc, but does not clearly ask whether the individual had private insurance either through the employer or self-purchased. Thus the statistics on the number of insured turn up an extremely low number of 10 percent. To supplement this information, we consulted a Consumer Population Survey Report on Health Insurance coverage (1995) and a report prepared by the American Hospital Association (1996) on

trends in employer coverage. These suggested that union members, workers in certain industries such as mining and manufacturing, and occupations such as professional or technical workers, and full-time workers were more likely to be covered. Hence we assigned the MEDCOVER variable a value of 1 if any of these criteria were satisfied. With this new variable, the coverage number went up to 61 percent. This is the variable we use in Table 3. [15]

The variable MEDICAL*UNEMPLOYED is assigned a value of 1 if the household could be classified as MEDICAL (as defined above), and the household head was also unemployed for a period of time in the previous year.

We control separately for the effect of poor health conditions, by including a variable BADHLTH. The survey asks the household head whether he considers his health to be (1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor. We construct a dummy variable that takes on the value 1 if the survey response is (5). This variable is interacted with DEBT to study if individuals experiencing poor health and indebtedness are more likely to file.

EXEMPTION refers to the dollar amount of bankruptcy exemptions that the household may take in its home state. We use the homestead exemption as well as the personal property exemption. The homestead exemption is an exemption for equity in owner occupied housing. For example, in 1996 the homestead exemption in Alabama was $10000, while in Arizona was $100,000. Most states also have exemptions for household belongings, equity in vehicles, retirement accounts, and a wildcard category that can be applied to any type of asset. The exemption levels have changed over time in many

states. This data is available from various editions of Elias et al, *How to File For Chapter 7 Bankruptcy*.[16]

RENT refers to the annual rent or mortgage payment that the household pays. MISSED WEEKS refers to the number of weeks of work that the household head missed in the previous year due to illness. State (Maximum Marginal) Income Tax Rates (available from National Tax Foundation), Unemployment Rates and Per Capita Incomes (Bureau of Labor Statistics) are put in as additional controls for macrocconomic and business conditions, apart from the demographic variables like age, sex, marital status etc of the household head.[17]

3. Empirical Methodology

We use a probit model to explain the probability of bankruptcy filing by a household at time *t*. Our model can be specified as:

$$Y_{it}^{*} = \delta_0 + \delta_1 D_{it1} + \delta_2 D_{it2} + \ldots + \delta_{49} D_{it49} + t_{95} + t_{94} + X_{it} B_1 + \varepsilon_{it} \; ; \; i=1,\ldots,N, \; t=1..T \qquad (3.1)$$

$$Y_{it}=1 \text{ if } Y_{it}^{*} > 0$$

$$Y_{it}=0 \text{ if } Y_{it}^{*} \leq 0$$

for household i in year t.

Our latent variable is Y_{it}* and the observed dependent variable is Y_{it}. Y_{it} relates to a household *i's* decision (for expositional purposes) to file for bankruptcy in year *t*. The dataset identifies the state in which the household filed for bankruptcy. Thus we are able to assign every household to a particular state and look at the appropriate state-level variables, such as bankruptcy exemptions, tax rates etc. $D_{it1} \ldots D_{it49}$ are state dummies and t_{95}, t_{94} are year dummies. B_1 refers to the vector of coefficients associated with the explanatory variables included in X_{it}. ε_{it} is a random error term. Standard errors are

corrected using the Huber/White procedure, which allows error terms to be correlated over time for the same household.

4. Empirical Results

4.A. Probit Estimation

Table 3 presents the marginal effects from a probit regression, using cluster analysis which allows for error terms to be correlated for the same household over time. All regressions use PSID weights to make the sample representative of all families in the US. Table 7 uses the marginal effects to illustrate the economic significance of the relevant variables.

Specification 1 (Column 1 of Table 3) shows results for demographic variables, household income, asset and debt values. The effect on bankruptcy filings of being MALE, WHITE or MARRIED for heads of household is positive, but not significant. Individuals are significantly more likely to file at relatively younger ages. This is also clearly brought out in Figure 1, where individuals less than 45 years of age have higher filing probabilities. More educated people are less likely to file, and this result is similar to Fay et al (2002). The marginal effect of an additional year of education is to lower the probability of a bankruptcy filing by .03 percentage points. Dividing this by the average probability of filing in our sample, which is .4 percent, Table 7 shows that the number of bankruptcy filings would decrease by 7.5 percent a year.[18] To draw conclusions from this for the general population based on 1.3 million bankruptcy filings in 1999, this implies that an additional year of education would lead to 97,500 fewer bankruptcy filings in a year.

The likelihood of filing is significantly higher if the head owns a business *(p=0.80)*, and is increasing in the number of children in the household. As would be expected, high family wealth is significantly negatively associated with the probability of filing. An increase in family wealth by $1000 would cause nearly a 1 percent drop in the bankruptcy filing rate, or approximately 10,000 fewer filings per year (Table 7).

Apart from MEDICAL, to adequately control for the effect of other health related factors on the probability of filing, we include a number of variables. We include a measure of weeks of work missed due to own illness, MISSED WORK.[19] This coefficient is positive and significant in all specifications, suggesting that losing work days due to illness is associated with lost earnings or job loss, which in turn may cause strain on the household finances leading to bankruptcy. In terms of economic significance (Table 7), an additional week of missed work would cause the predicted probability of filing to increase by 2.5 percent-an additional 32,500 filings per year.[20] We also control for the fact that the household may have medical insurance, MEDCOVER. As may be expected, households with medical insurance are less likely to file for bankruptcy, though the effect is not statistically significant. None of the other papers use this variable as a control. Finally, we test to see if having medical problems *and* being unemployed is a significant predictor of bankruptcy filings. However, while the sign on the coefficient is positive, it's not statistically significant.

The main question that this paper seeks to answer is to what extent do medical bills contribute to bankruptcy filings. Thus in Specification 1, we include MEDDEBT along with DEBT and DEBTSQ (debt squared). We scale each of these variables by Family Income. The marginal effect associated with MEDDEBT is positive and

significant.[21] We find that a 10 percent increase in medical debt (as a fraction of income), would lead to a 20 percent increase in the probability of filing for bankruptcy.[22] In terms of the 1999 bankruptcy filing rate, this would imply an additional 260,000 filings per year. It is worth pointing out here that MEDDEBT includes people who took loans primarily to pay off credit card debts, car debts or mortgages, but who also listed medical debts as a reason for the loan. Between 1994-1996, the number of people who took loans primarily to repay credit card debt went up from 406 in 1994 to 439 in 1996. Out of these only 28 in 1994 and 31 in 1996 claimed medical debts as well. The number who reported any medical debt went up from 91 in 1994 to 98 in 1996.

The coefficient on DEBT (as a fraction of income) is positive as may be expected, while the coefficient on DEBTSQ is negative and significant, suggesting that at certain very high values of DEBT, the probability of filing may go down.[23]

Including other macroeconomic state-level variables also yielded significant results. The coefficient on state bankruptcy exemptions is positive, but not significant.[24] This tends to erode support for the strategic view of bankruptcy, since if individuals were filing simply to take advantage of the higher exemptions, we would expect this coefficient to be significant.

In terms of current expenditures, taxes and rent form a large fraction of all monthly payments. Therefore it's important to control for them in the regression analysis. The coefficient on both of these variables is positive and highly significant. A 0.1 percent increase in state tax rates would cause filings to rise by 16 percent, while a $1000 increase in annual rent or mortgage payments would cause filings to rise marginally by 0.1 percent.

Finally, we also include State Unemployment Rates. The larger the unemployment rate in the state, the larger the number of filings. A 0.1 percent increase in unemployment rates would cause filings to rise by 97,500 per year. State per capita income, PCI, is positive but insignificant.

The coefficients on these state-level macroeconomic variables and the above mentioned demographic variables are similar across different specifications. Therefore we do not refer to them again when we discuss different specifications. Instead we will focus only on the relevant variables of interest.

In Specification 2, we include (instead of MEDDEBT) as the explanatory variable, MEDDEBT1. Recall that MEDDEBT1 is DEBT interacted with MEDICAL1 i.e it's the debt level for those individuals who claimed medical debts as their *primary* reason for taking a loan. The marginal effect for this variable is positive and significant. A 10 percent increase in medical debts for these households would cause only a 0.5 percent increase in the bankruptcy filing probability, or an additional 6500 filings. Comparing the results on MEDDEBT and MEDDEBT1, the picture that emerges is not one of medical bills *driving* individuals to bankruptcy, but medical bills *in addition* to other debt problems that the household is already facing.

In Column (3), we interact BADHLTH with DEBT (scaled by Family Income), and use that instead to capture the effect of debt on households with medical problems. The estimated marginal effect is the same as the one associated with MEDDEBT1 in Column (2). This suggests that our measure of medical debtors comes close to what we're trying to capture. Surprisingly including BADHLTH as an additional explanatory variable in Columns (1) and (2) does not yield a significant coefficient. Thus already

indebted households with health problems are more likely to file than households with health problems and no major debts.

A concern with specifications (1)-(3) in Table 3 is that we may be biasing downwards the impact of medical debts on bankruptcy. This arises for two reasons. First, our DEBT variable does not change across the three years, so effectively MEDDEBT is capturing the effect of changes in income (the scaling variable), rather than debt, on bankruptcy probabilities. Secondly, as mentioned earlier, there is not much change in the number of people taking loans for medical reasons between any two years. Hence as a check on our results, we re-estimated the regression model using only the years 1994 and 1996 (Column (4)). While this does not get around the first problem, it does lead to greater variation in MEDICAL, allowing for better estimation. As we suspected, there was a significant increase in the estimated coefficient on MEDDEBT-the marginal effect rose to 0.011 (p-value=0.022) (from 0.009) i.e a 10 percent increase in medical debts would cause a 27.5 percent increase in the probability of filing. A similar re-estimation of MEDDEBT1 did not yield a significant coefficient, possibly due to the limited observations in MEDICAL1. The next section improves on this estimation by pooling together years for which there is data on DEBT levels. Moreover, by looking at data over longer periods of time, it allows more variation in the data, leading to better estimation.

4.B. Alternative Specifications and Checks

Table 4 replicates the estimation procedure described previously for a different period of time to check for robustness of results. We pool three years-1984, 1989 and 1994. The choice of years is dictated by the fact that questions relating to family wealth and debt levels are asked only in these years. Thus by pooling across these years, we are

actually able to control for changes in the debt and asset levels. There is however, some loss of uniformity in the way the questions are asked, and we are unable to get good responses for certain variables such as rent or mortgage payments, and medical coverage. Thus we present results for this panel with less than the full set of variables we had in Table 3. We further allow all state effects to be captured by the state dummy variables.

It is comforting to note that our main results do not change. Both MEDDEBT and MEDDEBT1 enter the regressions positively and with significant marginal effects. However, the size of the marginal effects is significantly larger. The effect of a 10 percent increase in MEDDEBT is to increase the probability of a filing approximately by 36 percent, while a corresponding increase in MEDDEBT1 increases the probability by 27 percent. These results could be driven by the relatively longer time period that is involved, allowing for more variation in the right hand side variables. We are effectively studying changes over five year periods rather than 1 year periods. Moreover, unlike the 1994-1996 panel, our DEBT variable does vary in these three years since information on DEBT is collected in all these years. Thus these numbers should be closer to the true values compared to the estimates for 1994-1996.[25] Judging by these numbers, medical debts could be held *responsible* for at most 27 percent of all bankruptcy filings. If we take any mention of medical debts in conjunction with other debt variables as the predictor variable, the number is clearly higher at 36 percent. However, all that this implies is that medical debts, like any other debt, increase the probability of a bankruptcy filing, but they are not the *major* factor behind the filing.

In column (3), we defined BADHLTH more broadly to include not only instances where the head of household reported being in poor health, but also instances where other

family members were reported to be in bad health. The coefficient on this variable is positive and significant suggesting that medical problems faced by family members are equally important in predicting bankruptcy filings. If we include only cases where the head was described as being in poor health, the coefficient does not turn up significant.

These results also carry forward to the case when we estimate the probability of filing for bankruptcy using Cox's Proportional Hazard Model (Table 5). The Cox model estimates the determinants of the probability of bankruptcy. The model relates the hazard rate $h(t)$ (the probability of filing bankruptcy at time t, conditional on not having filed bankruptcy uptil time t) to a set of observables X:

$$h(t) = h_0(t)\exp(X'\beta)$$

Where $h_0(t)$ is the baseline hazard rate at time t for the covariate vector set at 0 and β is a coefficient vector. This semi-parametric estimator assumes that the hazard ratio $h(t)/h_0(t)$ is constant over time and requires no assumptions about the baseline hazard.

The results confirm the results of the probit regressions. The coefficients on MEDDEBT (hazard ratio=2.34) and MEDDEBT1 (hazard ratio=1.024) are positive and significant. The coefficients indicate that the estimated hazard or risk of filing for bankruptcy increases by 1-2.5 times if an individual has medical debts, after adjusting for the effect of other variables in the model.

Since the PSID data has several limitations in terms of uniformity of questions across years, to assure ourselves of the robustness of results, we did cross-section regressions as well. We present the results for the year 1994 in Table 6. In any particular year, there is adequate cross-sectional variation in debt levels and total family incomes, to allow identification of coefficients on medical debts. We classify medical debtors in the

usual way. The number of observations drops to about 6500, but even with this limited sample size, the estimated marginal effect on MEDDEBT is 0.017 (*p-value=0.051*), which is similar to what we had before.[26]

To summarize, our results indicate that the effect of a 10 percent increase in MEDDEBT would be to increase total filings by about 36 percent. However, if we include only those individuals who claimed medical debt as their primary reason for taking a loan, for this group the probability is about 27 percent. Note that MEDDEBT includes people who may have other forms of primary debt, such as credit card, car or mortgages, but who also have some medical debt. Hence if we look at this variable alone, we are overstating the impact of medical debts on bankruptcy filings. The more relevant variable to see if bankruptcies are being *driven* by medical debts, is MEDDEBT1. This captures individuals with primarily medical debt. Thus we can conclude that medical debts are primarily responsible for 27 percent of all bankruptcy filings. Note that this is still much smaller than the percentage reported by Himmelstein et al (2005) of 50 percent and that reported by Domowitz and Sartain (1999) of 30 percent (for high medical debts). This is, however, higher than that reported by the Office for United States Trustees (in the US Department of Justice), which found that only 11 percent of households that filed for bankruptcy, had medical debts in excess of $5000-approximately 17 percent of average income for the year 2000.

5. Economic Consequences of Bankruptcy Filings

The key feature of the modern U.S. personal bankruptcy law is to provide debtors a financial fresh start through debt discharge. However, surveys of bankruptcy filers reveal that filers experience financial hardships, such as reduced access to credit, as a

result of a bankruptcy record. Empirical evidence in this regard is scant. Musto (2005) demonstrates that the removal of a Chapter 7 bankruptcy record from an individual's credit report leads to a substantial increase in the number and aggregate limit on cards offered to the individual. Long (2005) presents evidence to suggest that a household with a bankruptcy record is about 30 percent more likely to lose home ownership. Han and Li (2004) estimate the effect of personal bankruptcy filings on labor supply using data from the PSID. They find that filing for bankruptcy does not have a positive impact on annual hours worked by bankrupt households.

In this paper, we assess the impact of bankruptcy filings on homeownership, average hours worked by the household head, and access to health insurance coverage. We further study whether these effects are persistent or tend to die down after a period of time, and whether there are differential effects of medical bankruptcy filings as opposed to other reasons for filing. Our results indicate that there are significant negative effects of having a bankruptcy record and these effects tend to persist, even over a ten year period.

Results presented in Table 8 indicate that a previous bankruptcy filing has a significant negative impact on home ownership. The variable LAGGED BANKRUPT is a dummy variable equal to 1 which indicates that the individual had filed for bankruptcy at some point prior to the period under study i.e 1994-1996. Unlike Long (2005), our sample does not only include home owners, but all household heads whether or not they owned a home. Including all of the controls used in previous regressions, and allowing for state and time dummies, our results indicate that having a bankruptcy record lowers the probability of home ownership by about 10.5 percentage points. Given the average

home ownership rate of 55 percent, this translates approximately to a nearly 19 percent drop in the probability of home ownership. This drop in home ownership could be attributed to reduced access to credit as a result of having mortgage applications turned down. As Long (2005) points out, households interviewed in the 2001 Survey of Consumer Finances listed bad credit history as the main reason for why their credit applications had been rejected. From the PSID, it is possible to get information on why individual's had their mortgage applications rejected. However, this information is only available for some years. Nonetheless, we regressed the probability of a mortgage application being turned down if one had filed for bankruptcy before. The probability of being turned down (due to credit history problems, or low, unstable income) *if one has filed for bankruptcy before* is positive, though significant at about 15 percent.

We were interested in studying if the negative consequences of bankruptcy filings were somehow different for medical filers versus other filers. The PSID asks bankruptcy filers to provide a reason for the filing. A list of possible reasons could include medical debts, credit card debts, job loss etc. By medical filers, we mean those individuals who gave their *primary reason for filing* as medical bills. Our hypothesis is that if bankruptcy filings are induced by a sudden short-term increase in debts as a result of an illness, in the long run (the period after the filing), the income-debt levels would stabilize faster than for other filers. This would mitigate the negative effect of the filing for this group of debtors. Therefore, in Table 8, we study the effect on home ownership of medical filers, credit card filers and filers who had experienced job losses. The estimated marginal effect is barely significant at 10 percent for medical filers, while it is highly significant at 1 percent for credit card filers and job-loss filers. Hence our results suggest that the

probability of owning a home after bankruptcy is significantly lower for certain kinds of filers, as opposed to others.

Following Han and Li (2004), next we model the effect of bankruptcy filings on labor supply. The underlying assumption behind the notion of debt discharge incorporated in U.S. personal bankruptcy law is that discharge of debt will give the individual a fresh start after bankruptcy. It will preserve the incentive to work and therefore encourage human capital formation. We test for this by regressing average hours worked per week by the household head on whether the individual had filed for bankruptcy previously, using a Random Effects GLS model. Unlike Han and Li (2004), we find that the lagged bankruptcy filing dummy enters positively and significantly in the regression, with p-value equal to 0.001. Contrary to their theoretical predictions, we find that individuals respond to a filing by increasing their supply of labor and working longer hours. Intuitively, this can be explained by the fact that their access to credit is lowered after the filing, hence there is an incentive to work and save more, to insure against other eventualities. These results hold if we consider credit card filers (*coefficient=2.65, p-value=0.049*), but there is no significant increase in the case of medical filers. Hence, once again, our results suggest that there are less significant impacts of bankruptcy filings for medical debtors.[27]

Finally, we wanted to study whether the impact of a filing is most severe in the immediate aftermath of the filing, or does it persist over time. Our results indicate that there is persistence over time. We defined a dummy LAGGED BANKRUPT90 which includes only those filings that occurred between 1990-1994, not including 1994. Similarly, LAGGED BANKRUPT84 includes all those cases where filings occurred

between 1984-1994. The former captures the short-term impact of the filing on home ownership and labor supply, while the latter captures the long-term impact. As the table shows, the coefficient on home ownership is not significantly different for the two cases. This is also true for average hours worked. Thus the negative consequences of bankruptcy filings appear to last for long periods of time.[28]

Summarizing the results in this section, we find that having a bankruptcy record significantly lowers individual's ability to own homes. This effect is most significant for individuals who filed due to high credit card debt or because they experienced job losses. The results are less significant for medical filers. We justify this finding on the assumption that medical filers are more likely to be those who experienced a one-time adverse event, but have steady income-debt levels otherwise. This may reduce problems of credit access for them. Hence they are able to recover faster from a bankruptcy filing, as opposed to credit card debtors with more persistent debt and income problems. This could also explain our findings on hours worked by individuals. In general, a bankruptcy filing induces longer work hours per week compared to non-filers. This result holds most strongly for credit card filers. Finally, we find that the effects of a bankruptcy filing persist over time.

6. Conclusion

In this paper, we estimate a model of the household bankruptcy filing decision, using PSID data for the period 1994-1996 and a three year panel covering the years 1984, 1989 and 1994. The main aim in the paper is to test whether medical debts can be ascribed as the leading cause of bankruptcy filings. To this end, we first developed a classification of households into medical and other debtors. Then we regressed the

probability of bankruptcy on medical (and other) debts using a probit model and a hazard model. The study finds that while medical debts are significantly related to bankruptcy filings, the magnitude is not as high as is claimed by other authors.

We do not find support for the view that medical debts are the *leading* cause of bankruptcy filings. In fact, households who are most likely to file are those with *primarily* other forms of debt, such as credit card or car debts, who *also* incur medical debts. Altogether, a 10 percent increase in debts of these households would cause bankruptcy filings to go up by 36 percent on average. A 10 percent increase in debts of households with *primarily* medical debts would cause filings to go up by 27 percent on average.

We find support for the non-strategic adverse events view of bankruptcy. In support of the latter, we find that an adverse event such as losing work days due to illness significantly increases the likelihood of filing. The paper also draws attention to other expenditures incurred by the household that are important in the filing decision, such as rents (or mortgages payments) paid per year or the amount of taxes paid (proxied by state tax rates). Macroeconomic conditions like state unemployment rates etc. are also highly significant and are positively linked to bankruptcy filings.

Our study also documents post-bankruptcy impacts on filers. We find that filers are significantly less likely to own homes. They are more likely to work longer hours to make up for the reduced credit access after bankruptcy. These effects persist for long periods of time, and are less significant for medical filers.

Table 1

Sample Summary Statistics: 1994-1996 panel

	Mean	Std. Error
Head Age	44.87	16.50
White	.623	.484
Head Married	.512	.499
Head Own Business	.094	.292
Total Family Income	42264.46	51222.29
Male	.678	.467
Own House	.576	.494
Bankrupt	.004	.061
Medical Coverage	.605	.488
People with Poor Health	.053	.225
Length of Unemployment spell	1.13	5.61
Monthly Rent Payments	1099.29	9992.89
Total Debt (1994)	4495.05	19645.02
Monthly Mortgage Payments	553.46	6127.17
House Value	194203.5	1155690
Wealth (1994)	77215.53	301024.4
Bankruptcy Exemption[2]	69396.35	77776.79
Unemployment rate[3]	6.12	1.28
Per Capita Income[4]	21841.38	3016.29
Tax Rate[5]	5.41	2.92

[2] Data available from Elias et al, *How to File for Chapter 7 Bankruptcy*, various editions
[3] Data available from Bureau of Labor Statistics
[4] Data available from Census
[5] Data available from National Tax Foundation

Table 2: Profile of Filers and Non-Filers (percent)

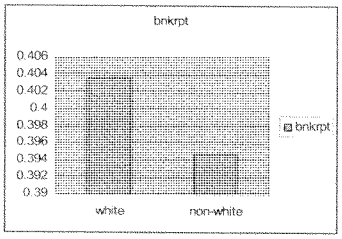
1994-1996 Panel

	Filers	Non-Filers
Male	65.8	68
White	63.5	62.3
Married	47.0	51.2
Own Business	15.2	9.4
Own House	36.4	58
Medical Coverage*	47.0	60.6
Unemployed	10.5	7.5

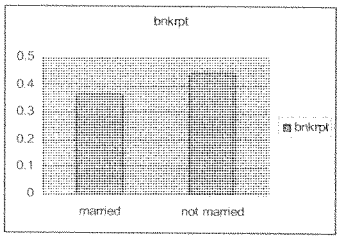
*This variable is constructed using identifiers discussed in the text.

Figure 1: Who is More Likely to File: Demographics of Bankruptcy Filers[6]

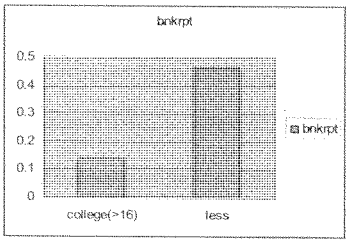
1994-1996 Panel



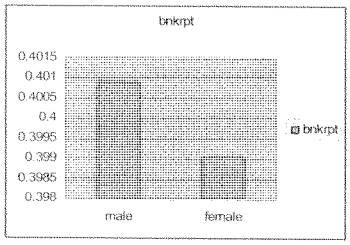
White people more likely



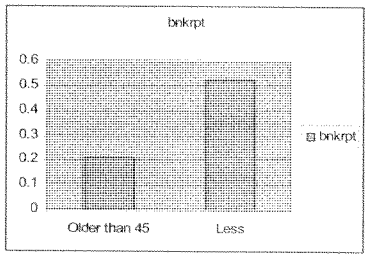
Unmarried more likely



Less Educated more likely



Males more likely



Younger more likely

[6] The numbers represent the percent of filers within each category. For example, WHITE represents the proportion of WHITE Bankrupts out of all WHITEs.

Table 2A: Tracking Health Shocks

1994-1996 Panel

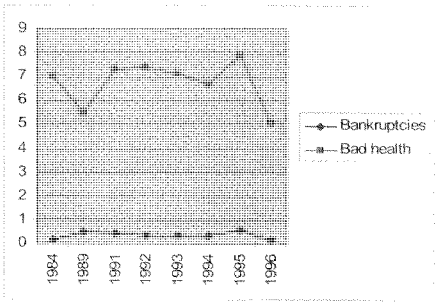
Year	Bankruptcies (percent)	Bad health (percent)	Medical Debt/Income (percent)	Average Family Income	MEDICAL1 (Number who claimed medical debts as the primary reason for taking a loan)	MEDICAL (Number who claimed medical debts as the reason for taking a loan)
1994	0.44	5.39	0.21	41663.05	34	69
1995	0.51	5.25	0.31	43301.91	36	72
1996	0.19	5.32	0.24	44531.26	38	73

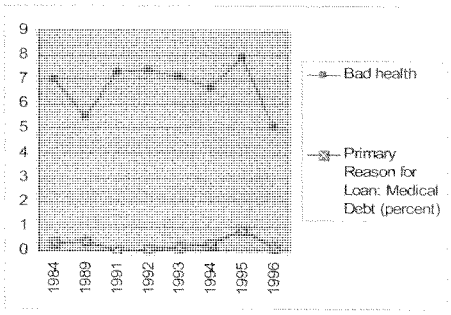
1984-1994 Panel

Year	Bankruptcies (percent)	Bad health (percent)	Medical Debt/Income (percent)	Average Family Income	MEDICAL1 (Number who claimed medical debts as the primary reason for taking a loan)	MEDICAL (Number who claimed medical debts as the reason for taking a loan)
1984	0.11	7.0	0.07	24100.54	22	46
1989	0.42	5.5	0.12	33181.01	31	59
1994	0.35	6.6	0.18	39595.28	38	75

Note: Summary statistics for the year 1994 vary across the two panels due to differences in sample size and observations used.

Figure 2: Bankruptcies, Bad Health and Medical Loans





Note: These graphs include some years that are not part of the sample used in the regressions.

Table 3
Probit Results Explaining Household Bankruptcy Filings: Marginal Effects:1994-1996

	(1) 1994-1996	(2) 1994-1996	(3) 1994-1996	(4) 1994 and 1996
Age	0.0003	0.0002	0.0002	0.0001
	(.105)	(.203)	(.149)	(.562)
Age Square	$-4.54ex10^{-}$	$-3.82x10^{-6}$	$-4.39x10^{-6}$	$-1.84x10^{-6}$
	(.038)	(.075)	(.050)	(.408)
Male	.0003	0.0007	0.0004	0.0006
	(.800)	(.574)	(.719)	(.673)
White	0.0009	0.0008	0.0008	0.0017
	(.467)	(.473)	(.499)	(.261)
Education	-0.0002	-0.0003	-.0003	-0.0002
	(.203)	(.130)	(.127)	(.419)
Married	0.0008	0.0005	0.0005	-.0013
	(.607)	(.734)	(.700)	(0.455)
Number of Children	.0003	.0004	.0004	0.0008
	(.360)	(.243)	(.237)	(.106)
Own Business	0.005	0.0049	0.0048	0.004
	(.080)	(.079)	(.082)	(.205)
Wealth('000)	-.00003	-.00003	-.00003	-.00004
	(.002)	(.006)	(.000)	(.000)
Own House	0.0007	0.0004	0.0004	0.001
	(.647)	(.777)	(.759)	(0.485)
Medical Coverage	-0.0014	-0.0015	-.0016	-0.002
	(.202)	(.153)	(.143)	(0.128)
MEDICAL*unemployed	$4.16x10^{-7}$	$5.98x10^{-7}$		
	(.469)	(.284)		
MEDDEBT/Income	.008			0.011
	(.034)			(0.025)
MEDDEBT1/Income		0.0002		
		(.000)		
Bad Health*Debt/Income			.0002	
			(.000)	
DEBT/Income	$7.66x10^{-6}$	$7.02x10^{-6}$	$7.06x10^{-6}$	$7.16x10^{-6}$
	(.006)	(.016)	(.016)	(.019)
$(DEBT/Income)^2$	$-7.45x10^{-10}$	$-6.62x10^{-10}$	$-6.68x10^{-10}$	$-6.93x10^{-10}$
	(.005)	(.017)	(.017)	(.022)
Rent	$6.20x10^{-6}$	$4.29x10^{-6}$	$4.26x10^{-6}$	
	(.020)	(.200)	(.202)	
Weeks Missed (Illness)	0.0001	0.0001	0.0001	0.0001
	(.041)	(.048)	(.048)	(.009)
State PCI	$2.32x10^{-}$	$1.81x10^{-7}$	$1.13x10^{-7}$	$-3.23x10^{-}$
	(.937)	(.952)	(.970)	(.297)
State Exemption	$2.85x10^{-7}$	$3.12x10^{-7}$	$2.72x10^{-7}$	$2.43x10^{-7}$
	(.426)	(.629)	(.429)	(.606)
State Tax Rate	.0066	.0064	0.0065	0.002
	(.004)	(.005)	(.006)	(.249)
State Unemployment Rate	.0034	0.0030	0.0030	0.003
	(.041)	(.070)	(.070)	(.099)
Observations	18259	18259	18259	11056

1. p-values in parentheses
2. All regressions include a constant, state and time dummies
3. All regressions use PSID weights, and the standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.

Table 4
Probit Results Explaining Household Bankruptcy Filings: Marginal Effects
1984-1994 (3 years)

	(1)	(2)	(3)
Age	0.0002	0.0001	.0001
	(.287)	(.404)	(.385)
Age Square	-3.28×10^{-6}	-2.78×10^{-6}	-2.81×10^{-6}
	(.104)	(.149)	(.148)
Male	-.00002	-.0001	.0003
	(.985)	(.906)	(.790)
White	0.0005	0.0006	.0008
	(.652)	(.575)	(.414)
College	-0.0026	-0.0022	-.002
	(.006)	(.024)	(.003)
Married	-.0011	-.0008	-.001
	(.410)	(.507)	(.310)
Own Business	0.0047	0.0044	.005
	(.097)	(.104)	(.099)
Wealth('000)	-.00003	-.00003	-.00004
	(.000)	(.000)	(.000)
Own House	0.0004	0.0005	.0005
	(.720)	(.668)	(.632)
Medical Coverage	.0009	.0006	.0003
	(.555)	(.650)	(.800)
MEDDEBT/Income	.015		
	(.010)		
MEDDEBT1/Income		.011	
		(.106)	
Bad Health			.002
			(.079)
DEBT/Income	4.89×10^{-3}	5.26×10^{-3}	4.83×10^{-3}
	(.020)	(.022)	(.025)
$(DEBT/Income)^2$	-4.01×10^{-5}	-4.59×10^{-5}	-4.23×10^{-5}
	(.046)	(.046)	(.021)
Weeks Missed (Illness)	0.0001	0.0001	.0001
	(.022)	(.015)	(.021)
State Dummies	Yes	Yes	Yes
Observations	19339	19339	20671

1. p-values in parentheses
2. All regressions include a constant, state and time dummies
3. All regressions use PSID weights, and the standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.

Table 5: Cox Proportional Hazard Model
Results Explaining Household Bankruptcy Filings: Coefficients 1994-1996

	(1)	(2)
Age	0.092	0.088
	(.064)	(.606)
Age Square	-.001	-.001
	(.023)	(.030)
Male	-.269	-.190
	(.352)	(.518)
White	.215	0.241
	(.443)	(.391)
Education	-0.049	-0.013
	(.269)	(.778)
Married	.208	.283
	(.530)	(.379)
Own Business	0.631	0.906
	(.055)	(.005)
Own House	-.819	-.045
	(.009)	(.893)
Medical Coverage	-.216	-.216
	(.357)	(.353)
MEDDEBT/Income	1.104	
	(.001)	
MEDDEBT1/Income		.028
		(.000)
DEBT/Income	.0014	.001
	(.004)	(.000)
$(DEBT/Income)^2$	-1.39×10^{-7}	-1.15×10^{-7}
	(.000)	(.001)
Weeks Missed (Illness)	0.018	0.017
	(.004)	(.006)
State Dummies	Yes	Yes
Observations	22175	22175

1. p-values in parentheses
2. All regressions include a constant, state and time dummies
3. All regressions use PSID weights, and the standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.

Table 6: Cross-Section Results
Probit Results Explaining Household Bankruptcy Filings: Marginal Effects
1994

Age	0.0002
	(.627)
Age Square	-1.77×10^{-6}
	(.581)
Male	-0.001
	(.507)
White	0.001
	(.546)
College	-0.0026
	(.006)
Married	-0.002
	(.303)
Own Business	0.011
	(.129)
Wealth('000)	-.00007
	(.000)
Own House	0.003
	(.290)
Medical Coverage	.001
	(.290)
MEDDEBT/Income	.017
	(.051)
DEBT/Income	.00001
	(.001)
(DEBT/Income)^2	-9.5×10^{-13}
	(.002)
Weeks Missed (Illness)	0.0002
	(.004)
Observations	6356

1. p-values in parentheses
2. All regressions include a constant
3. All regressions use PSID weights, and the standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.

Table 7: Economic Impact
(Based on Average Sample Filing Rate of 0.4 percent)

	Change	Percent Change in Filing Rate	Number** of filings
Education	+1 year	-7.5	-97,500
Family Wealth	+$1000	-0.75	-9750
Rent/Mortgage	+$1000	0.1	1500
MEDDEBT/Income	+10 percent	36	468,000
MEDDEBT1/Income	+10 percent	27	351,000
Missed Work	+1 week	2.5	32,500
Tax Rate	+0.1 percent	15	195,000
Unemployment Rate	+0.1 percent	7.5	97,500

** Based on 1999 bankruptcy filing rate of 1.3 million

Table 8
Results Explaining Consequences of Household Bankruptcy Filings: 1994-1996

Dependent.Vars	Independent.Vars	Marginal.Eff	Coefficients
Own House[1]	Lagged Bankrupt	-.105***	
Own House[1]	Medical Bankrupt	-0.11*	
Own House[1]	CreditCard Bankrupt	-0.14***	
Own House[1]	JobLoss Bankrupt	-0.17***	
Hours Worked[2]	Lagged Bankrupt		2.54***
Hours Worked[2]	Creditcard Bankrupt		2.65**
Hours Worked[2]	Medical Bankrupt		-2.37
	Persistence of Effect		
Own House[1]	Lagged Bankrupt90	-0.085**	
Own House[1]	Lagged Bankrupt84	-0.082**	
Hours Worked[2]	Lagged Bankrupt90		2.53**
Hours Worked[2]	Lagged Bankrupt84		2.61***

***significant at 1 percent**significant at 5 percent *significant at 10 percent

Notes

1. Regressions estimated using a probit model. Own House is a dummy equal to 1 if the household owned a home in year t, and 0 otherwise. Hours worked measures the average work hours per week for the household head in any year. The standard errors are corrected using the Huber/White procedure, which allows error terms for the same household to be correlated over time.
2. Regressions estimated using Random Effects GLS model.
3. All regressions include a constant and time dummies, and controls for head age, sex, race, education, marital status, wealth, debt and income levels. Controls are also included for state-level macroeconomic conditions such as state tax rates, per capita incomes and unemployment rates. Other state-level unobservables are captured through the use of state dummies.
4. Lagged Bankrupt is a dummy variable equal to 1 if the individual had filed for bankruptcy at any time before 1994. Lagged Bankrupt90 is a dummy equal to 1 if the individual filed between 1990 and 1994. Lagged Bankrupt84 is similarly equal to 1 if the individual filed between 1984-1994. Medical Bankrupt refers to those subset of filings where the primary reason for filing was medical debts. CreditCard Bankrupt refers to those filings where the primary reason was credit card debt. Job Loss Bankrupt refers to those filings where the primary reason was job loss.
5. All regressions use PSID weights.
6. These results hold even if we look only at the years 1994 and 1996, allowing for greater variation in the right -hand side variables.

References

Current Population Reports, Health Insurance Coverage 1995, 60-195

http://www.census.gov/prod/2/pop/p60/p60-195.pdf

Domowitz, Ian and Sartain, Robert (1999), "Determinants of the Consumer Bankruptcy Decision", *Journal of Finance*, Vol. 54, No.1, Feb 1999, 403-420

Doty, Michelle, Edwards, Jennifer and Holmgren, Alyssa (2005), "Seeing Red: Americans Driven into Debt by Medical Bills", Commonwealth Fund pub#837, August 2005

http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf

Fay, Scott, Hurst, Erik and White, Michelle (2002), "The Household Bankruptcy Decision", *American Economic Review*, Vol. 92 No.3, June 2002, 706-718

Gross, David B. and Souleles, Nicholas S (2002), "An Empirical Analysis of Personal Bankruptcy and Delinquency", *Review of Financial Studies*, Spring 2002, 15(1), 319-347

Han, Song and Li, Wenli (2004), "Fresh Start or Head Start? The Effect of Filing for Personal Bankruptcy on the Labor Supply", Working paper 04-5, Federal Reserve Bank of Philadelphia

Himmelstein, David, Warren, Elizabeth, Thorne, Deborah and Woolhandler, Steffie (2005), "Illness and Injury as Contributors to Bankruptcy", *Health Affairs* (Web Exclusive), 2 Feb 2005

Health Care Costs Survey, (August 2005), *Kaiser Family Foundation(KFF)*/Harvard School of Public Health

http://www.kff.org/newsmedia/upload/7371.pdf

Long, Cheryl (2005), "Negative Effects of Personal Bankruptcy Filings for Home Owners: Reduced Credit Access and Lost Option Value", *Proceedings*, Federal Reserve Bank of Chicago, April 2005

Musto, D.K. (2002), "What Happens when Information Leaves the Market? Evidence from Post-Bankruptcy Consumers" Journal of Business, forthcoming

Recent Trends in Employer Health Insurance Coverage and Benefits (1996), American Hospital Association

http://www.lewin.com/NR/rdonlyres/egugxizk7qh4dvcnszrg2rtx5atxny3okbw3oem33etampl3hcjciyaluowmvqn3s6c6x7botmryfrio6kvg5qarexb/AHA_Insurance_Report.pdf

http://www.census.gov/prod/2/pop/p60/p60-195.pdf

Sullivan, Teresa, Warren, Elizabeth, and Westbrook, Jay Lawrence (1989), "As we forgive our debtors: Bankruptcy and consumer credit in America", New York: Oxford University Press, 1989

Zywicki, Todd (2004), "An Economic Analysis of the Consumer Bankruptcy Crisis",Law and Economics Working paper series 04-35, *George Mason University*. Link to paper:http://ssrn.com/abstract_id= 587901

US Department of Justice and Executive Office of United States Trustees (2000), "The Class of 2000:Bankruptcy By The Numbers", available at : http://www.usdoj.gov/ust/press/articles/abi01octnumbers.html

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[1] Homestead exemptions refer to exemptions against equity in owner occupied homes. Personal property exemptions refer to exemptions taken against cars, jewellery etc.

[2] http://www.abs-cbnnews.com/storypage.aspx?StoryId=17748

[3] Households' financial benefit from filing for bankruptcy under Chapter 7 is the value of debt discharged, and their financial cost is the value of non-exempt assets that they must give up. Households' net financial benefit is the difference between the two.

[4] A re-examination of their data by Dranove and Millenson (Health Affairs,25,no.2,2006), suggests that medical bills are a contributing factor in personal bankruptcies in only 17 percent of cases. This is again based on just the survey of filers.

[5] They include as medical debtors people who cited any form of addiction or uncontrolled gambling, or had experienced the birth or death of a family member. The respondents included low-income people who had no jobs (not necessarily due to illness), had low earnings in the past, and other unpaid debts.

[6] http://www.kff.org/newsmedia/upload/7371.pdf

[7] http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf

[8] Thus in year 2000, with an average family income of $30,000, this would mean that $600 in medical debts would be classified as a "high" level of debt, pushing people to file for bankruptcy. However, as pointed out by the United States Trustee Program, the average level of medical debt among bankruptcy filers was $2600-this figure too was skewed upwards by the fact that a few debtors had medical debt in excess of $50,000. http://www.usdoj.gov/ust/press/articles/abi01octnumbers.html

[9] The United States Trustee Program is a component of the Department of Justice responsible for overseeing the administration of bankruptcy cases and private trustees

under 28 U.S.C. §586 and 11 U.S.C. §101, *et seq*. It consists of 21 regional U.S. Trustee Offices nationwide and an Executive Office for U.S. Trustees (EOUST) in Washington, DC. "The Class of 2000: Bankruptcy By the Numbers" http://www.usdoj.gov/ust/press/articles/abi01octnumbers.html

[10] Gross and Souleles (2002) do not find lack of health insurance to be a significant predictor of bankruptcy.

[11] 1984 is the first year for which the household reported a bankruptcy filing. We realize that there are potential errors associated with imperfect recall, but are constrained to work with the given data.

[12] A possible reason for the low percentage of insured individuals could be that the survey question on medical insurance asks respondents if they were covered by Medicare, Welfare, Medical Services etc, but it may not include private insurance or employer provided insurance, and it does not include Medicaid. More detailed questions on health insurance were asked in the surveys after 1999.

[13] As far as possible, we try to include only cases where the loan was taken prior to the filing. This is true for the 1994-1996 panel. For the 1984-1994 panel, we have had to classify as medical all those who ever reported taking a loan for medical reasons, since we do not have data on when exactly the loan was taken. This is likely to make our measure of MEDICAL somewhat noisy for that panel, though we do not think this a big problem since if households did resort to taking a (recent) loan for medical reasons, they are likely to have been experiencing medical problems and accumulating medical bills for some time.

[14] This question is asked of all bankruptcy filers as well as non-filers. About 4 percent of bankruptcy filers had taken a loan to repay medical debts, while 13 percent had taken a loan to repay credit card debt. The ratio of medical filers to credit card debt filers is thus around 30 percent. This is approximately the same proportion as the number of people who filed for medical cost reasons to the number of people who filed for credit card debt reasons (32 percent). Of all those who we classified as MEDICAL, about 1 percent filed for bankruptcy.

[15] We could also create a weighted average of all these characteristics for each individual, and assign MEDCOVER a value of 1 only when more than 50 percent of the criteria are met.

[16] *How to File for Chapter 7 Bankruptcy*, Elias, Stephen, Renauer, Albin and Leonard, Robin (Publisher: Nolo)

[17] State Maximum Marginal Tax Rates change for a few states for every year in the sample.

[18] Interestingly, this is close to the number derived by Fay et al (2002) of 8 percent.

[19] The average number of weeks missed was 1.

[20] Surprisingly, Fay et al (2002) do not find a significant impact of adverse events such as unemployment spells experienced by the household head in the previous year or health problems.

[21] As a robustness check, we tried dropping a few variables, like MEDCOVER, MEDICAL*UNEMPLOYED from the model, but the results did not change.

[22] This is obtained by dividing the percentage point marginal effect by 0.4 , the average filing probability.

[23] This is similar to results reported by Fay et al (2002)

[24] The p-value associated with the coefficient estimate is 0.80, but is much higher for the marginal effect.

[25] This further suggests that estimates obtained by Fay et al (2002), who assume constant debt levels between the five year periods may be biased downwards as well.

[26] Again, in this case, no significant coefficients could be estimated for MEDDEBT1.

[27] These results hold when we use instruments for the bankruptcy variable, such as the state bankruptcy exemption. This variable is positively correlated with bankruptcy filings, but is not likely to be correlated with home ownership. (For our sample the correlation is close to 0).

[28] If we take business ownership as the dependent variable, the coefficient on lagged bankruptcy is positive and significant (at 10 percent) only if we include all cases between 1980 and 1994. There is no short-term impact of a filing on business ownership. Another variable that we tried is insurance coverage. In this case, there is a negative and significant effect of previous bankruptcy filings (LAGGED BANKRUPT) on health insurance coverage.

STATEMENT OF

JANE E. MCNAMARA, PRESIDENT AND CEO OF GREENPATH, INC.

HEARING ON "MEDICAL DEBT: CAN BANKRUPTCY REFORM FACILITATE A FRESH START?"

BEFORE THE U.S. SENATE COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON ADMINISTRATIVE OVERSIGHT AND THE COURTS

OCTOBER 20, 2009

Chairman Whitehouse, Ranking Member Sessions, and Members of the Subcommittee, thank you for the opportunity to submit written testimony regarding the role of pre-bankruptcy credit counseling as it pertains to people filing for bankruptcy due to medical debt. I am president and CEO of GreenPath, a 501(c)(3) non-profit credit counseling company that has been in business since 1961. We are a national provider of credit counseling, financial education, housing counseling, and bankruptcy counseling and education. In 2008, we provided pre-bankruptcy counseling to about 185,000 consumers.

At GreenPath, our counselors interact with consumers in a one-on-one counseling session. We believe that our pre-bankruptcy counseling serves two very important purposes:

1. It enables consumers make an informed decision about bankruptcy.
2. It gives consumers the budgeting foundation they need to successfully emerge from the bankruptcy process.

Making an informed decision about bankruptcy may be a non-issue for people who are forced to file for bankruptcy due to a medical tragedy. That was clearly the case for Kerry Burns because she knew that filing for bankruptcy was the right decision for her.

However, I would like to discuss the second purpose in more detail. Pre-bankruptcy counseling is the only time in the bankruptcy process when the consumer has an opportunity to talk to a non-profit counselor in a one-on-one format. At GreenPath, we strongly believe that this is a significant opportunity to provide budgeting and money management assistance to help ensure that the consumer is able to manage their financial obligations --- whether or not they file for bankruptcy, and regardless of the reason for their financial crisis.

Bankruptcy alone is not a solution to a consumer's financial problems. If someone is being forced to file for bankruptcy due to medical debt or any other reason, they are doing so because they don't have enough income to pay their bills. And after the bankruptcy is filed, they still have commitments to pay their bills and ongoing household expenses. What a benefit it is for these consumers to be able to talk to a counselor. Someone who can help them develop a budget and a plan for how they can live their life moving forward without going further into debt. This is an immensely powerful opportunity.

In the case of Chapter 13 bankruptcy, consumers must adhere to a payment program and continue paying down their debts through the Chapter 13 trustee. As they live their lives and deal with unexpected expenses, staying on a Chapter 13 payment program can be extremely difficult. This is why so many Chapter 13 bankruptcies fail. According to a 2007 study by the Federal Reserve Bank, nearly 20 percent of Chapter 13 bankruptcies are dismissed without ever obtaining confirmation of even one plan. Overall, less than 40 percent of Chapter 13 debtors actually receive a financial fresh start by having their debts discharged. A study by the National Bankruptcy Research Center, published in the American Bankruptcy Institute Journal on October 9, 2009, indicated that dismissal rates were 13.7 percent lower for Chapter 13 filers who received pre-bankruptcy counseling.

I have always believed that truly effective counseling can only be achieved through one-on-one interaction with consumer and counselor. If all providers of pre-bankruptcy counseling are not providing one-on-one counseling, assisting consumers in developing a budget, and providing them with an action plan, then maybe we need to raise the bar. Let's not throw the proverbial baby out with the bath water. If you believe that the current counseling process does not provide enough value for medical debt bankruptcy consumers, let's improve the current counseling process. Let's ensure that ALL consumers

filing for bankruptcy have a pleasant, non-judgmental experience that adds value and helps them successfully manage their finances --- now and in the future.

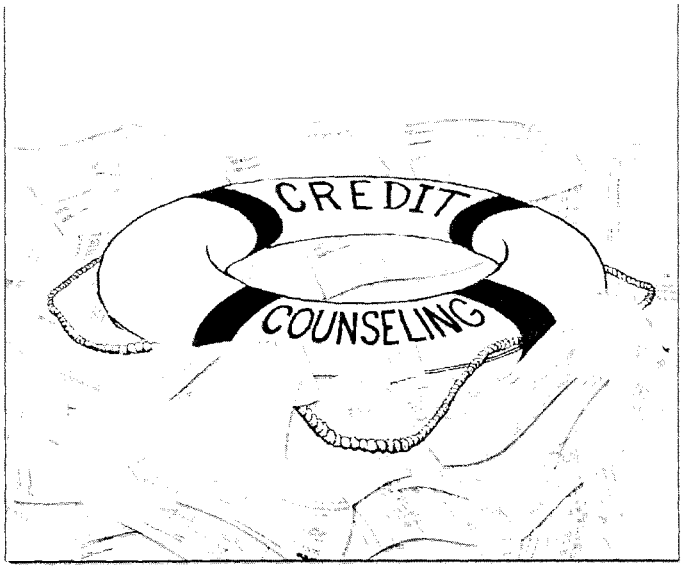
Chairman Whitehouse, Ranking Member Sessions, and Members of the Subcommittee, thank you for organizing this hearing and working to ensure that people going through bankruptcy receive the appropriate assistance. I would be pleased to work with the Subcommittee as you move forward with this issue. Thank you for your consideration.

NBKRC
National Bankruptcy Research Center

Financial Education Foundation
Money Management International

Credit Counseling Value Study

May 2009



Credit Counseling Value Study
By The Numbers

Money Management International Financial Education Foundation in collaboration with the National Bankruptcy Research Center and Experian recently completed the second phase of a comprehensive study of the value of Credit and Bankruptcy Counseling. Unprecedented access to millions of consumer's experiences covering a six year period has yielded extraordinary findings:

5 major findings:

1. **43.1%** - The decrease in the bankruptcy filing rate of counseled consumers entering a debt management plan versus those who did not enter a plan.
2. **15.2%** - The percent of consumers receiving counseling and issued a pre-filing bankruptcy counseling certificate that found they did not need to file for bankruptcy.
3. **7.19%** - The average credit score improvement for consumers who received pre-filing bankruptcy counseling and did not file for bankruptcy.
4. **0.68%** - The average credit score improvement for consumers in a control group who did not receive counseling from 2006 to 2008.
5. **0.5%** - The average incremental credit score improvement for consumers receiving bankruptcy counseling and who subsequently received debt relief from bankruptcy.

4 data sources:

1. **10.7 million** - The number of bankruptcy records utilized from the National Bankruptcy Research Center.
2. **2.7 million** - The number of counseling records examined in the study from four large agencies.
3. **1 million** – The number of randomly selected credit reports and scores used as a national sample.
4. **966 thousand** - The number of credit reports pulled from consumers receiving pre-bankruptcy counseling.

1 conclusion:

1. **Pre-filing credit counseling is of significant value** to consumers whether they file for bankruptcy or they do not.

About the Participants:

NBKRC

The National Bankruptcy Research Center (NBKRC) is the premier source for the most current bankruptcy research and statistics. The NBKRC provides industry leading analytics, providing micro- and macro- level insight into the events that occur during the lifecycle of a bankruptcy case. Subscribers include analysts, financial institutions, government entities, universities, and members of the media. The NBKRC bankruptcy database contains complete information dating back to 1995.

MMI Foundation

Founded as an extension to the education and counseling Money Management International provides, the MMI Financial Education Foundation operates to educate the general public on sound personal financial skills and money management principles by partnering with national organizations that develop, deliver, and support programs that teach those skills and principles, as well as by, sponsoring research projects into personal financial issues of national importance.

Acknowledgements:

Experian contributed to Phase 2 of this study by providing expertise and detailed information about the credit profiles and behaviors of the consumers in the sample. The analysis was conducted using VantageScore as the credit scoring benchmark. VantageScore is the first single credit scoring model to be developed jointly by all three national credit reporting companies to deliver a highly predictive, consistent and easy to understand credit risk score. For more information about Experian, please visit http://www.experian.com.

In addition, we would like to thank the credit counseling agencies for participating in the study, further demonstrating that financial counseling makes a difference.

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I. General Overview

This study provides insight into the effectiveness of counseling or briefing programs offered through credit counseling agencies, including: (1) credit counseling, (2) pre-bankruptcy filing counseling, (3) pre-discharge education, and (4) debt management programs.

These programs provided consumers with knowledge and skills to effect a change in their personal financial management, including credit behavior resulting in improved credit profiles and scores.

Specifically, an analysis of consumer Vantage scores and credit attributes demonstrated that consumers who received credit counseling or pre-bankruptcy counseling were in a better financial position two years later than those who did not.

Consumers who received pre-bankruptcy filing counseling and did not file bankruptcy also showed significant improvement in credit behavior as demonstrated by key indicators.

II. Background on Counseling Programs

Prior to the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), credit counseling agencies offered the following types of assistance to consumers in financial distress:

1. Credit Counseling

- Assistance with goal setting, budgeting, financial management and understanding credit.
- Assistance with mortgage, reverse mortgage and other housing issues
- A majority of those counseled took guidance from their counselor and continued to manage their debt on their own.
- Prior to BAPCPA, there was no requirement for a credit counseling or briefing session prior to filing for bankruptcy.

2. Debt Management Program (DMP)

- A DMP is a structured repayment plan offered at the conclusion of a credit counseling sessions for consumers who have significant unsecured debt and cannot meet the current minimum payments on their obligations.
- Credit counseling agencies work with creditors on behalf of their clients. The credit counseling agency may negotiate concessions with creditors that are beneficial to their clients, such as lower interest rates, reduction in fees and minimum monthly payment requirements.

BAPCPA was enacted on October 17, 2005. One of the key provisions of the legislation was to require credit briefings or credit counseling sessions for all consumers who filed for personal bankruptcy.

A consumer who is in a financially precarious position and is looking to file bankruptcy must provide evidence of having received counseling from a credit counseling agency approved by the Executive Office of the United States Trustee or seek an exemption from the counseling requirement from the bankruptcy court. In either scenario, consumers who file bankruptcy, have to complete a pre-discharge education course to get a discharge from bankruptcy.

1) **Credit Briefing (Pre-filing bankruptcy counseling)**
   - A credit briefing session required for consumers in anticipation of filing a personal bankruptcy petition. This session must be provided by an approved non-profit budget and credit counseling agency
   - Specific criteria regarding this requirement can be found at www.usdoj.gov

2) **Discharge Education (Pre-discharge Education)**
   - An educational session to emphasize fiscal responsibility prior to debts being discharged.

III. Overview of Results

There were two components to this study identified as Phases 1 and 2. A high level summary of these phases is listed below:

1. **Phase 1**
   - The goal of Phase 1 was to provide insight into the effectiveness of **pre and post** BAPCPA programs by examining changes in consumers' financial profiles and bankruptcy filing rates.
   - The study collected data from 4 large credit counseling agencies which provided counseling to consumers located all across the United States. A total of 2.7 million counseling client records were collected, the majority of which were from clients who received counseling between January 1993 and February 2008.
   - To determine bankruptcy filing rates and other bankruptcy related information, the consumers were matched against a national bankruptcy database.

2. **Phase 2**
   - The goal of Phase 2 was to provide insight into the effectiveness of **post** BAPCPA programs by examining changes in consumers' credit profiles and Vantage scores.

- During this phase, the study was expanded to look at the entire lifecycle of the consumer from the time of pre-filing counseling until two years after counseling.
- Credit profile information, was obtained from a national credit bureau (Experian) which provided Vantage Scores and Stagg (Statistical Aggregate) variables.

3. **Future Phases**
In the future, additional phases will be considered. These include 1) analyzing other comparison groups such as pre-BAPCPA credit counseled consumers and 2) surveying consumers to collect information about their experiences with credit counseling and pre-bankruptcy filing counseling.

Phase 1 Summary of Results

1.1 The average debt per consumer was greater after 2005 than before the enactment of BAPCPA.

1.2 Filing rates for consumers seeking credit counseling increased from 20.7% pre-BAPCPA to 30.1% post-BAPCPA.

Pre-filing bankruptcy counseling consumers had a filing rate of 84.8%, i.e., 15.2% of all clients receiving pre-filing counseling did not file bankruptcy during the study period.

- The increased filing rate can be partially attributed to the larger debt burdens of consumers in post-BAPCPA.

1.3 Consumers who entered a DMP had a significantly lower incidence of bankruptcy filing.

- It appears that DMPs effectively allow consumers to resolve their financial difficulties without having to file for bankruptcy.

1.4 For those consumers who received credit counseling and subsequently filed for bankruptcy, there was a decrease in the number of Chapter 7 filings and an increase in Chapter 13 filings.

- This finding is consistent with the trends in the national bankruptcy chapter distribution. Of note: many consumers who would have otherwise filed for bankruptcy sometime after October 2005, filed prior to the enactment of BAPCPA causing a temporary shift in Chapter distribution.

1.5 Credit counseled consumers who filed for bankruptcy had lower dismissal rates in comparison to the national sample for both Chapter 7 (1.6% vs. 2.1 %) and Chapter 13 (30.9% vs. 44.6%) filings.

- Credit counseled consumers are more likely to successfully complete the bankruptcy process whether their debts are discharged in a few months through a Chapter 7 bankruptcy or they enter a multi-year repayment plan through a Chapter 13 bankruptcy.

Phase 2 Summary of Results

Consumers who received pre-bankruptcy counseling exhibited better credit behavior in comparison to consumers who did not receive pre-bankruptcy counseling.

These consumers demonstrated greater improvement in:

2.1 Vantage scores between 2006 to 2008

Credit scores for pre-filing counseled consumers, regardless of chapter filed, rose 7.69% versus 3.65% for non-counseled filers.
Credit scores for pre-filing counseled consumers who did not file bankruptcy after counseling rose by 7.19%.
Credit scores for a national sample with credit profiles similar to those who filed but receiving no counseling and who did not file and were not counseled rose 0.68%.
Credit scores for pre-filing counseled consumers filing Chapter 7 rose 9.1% versus 5.5% for non-counseled filers.

a) Vantage scores provide a cumulative snapshot of the consumers' credit behavior. In addition, higher Vantage scores generally allow consumers to access credit at lower interest rates.

2.2 Number of delinquent accounts

Pre-bankruptcy filing counseled consumers had significantly fewer delinquent accounts across all types of credit lines—a reduction of 27.5% for those that filed bankruptcy and a reduction of 25.6% for those that did not file bankruptcy.

- The lower delinquency statuses appear to indicate that consumers who receive pre-bankruptcy filing counseling are better able to

manage their credit obligations than those who did not receive counseling.

2.3 Time account maintained in "current" status

Consumers who received pre-filing bankruptcy counseling maintained their accounts in a current status for longer periods of time than non counseled consumers. The time since their last delinquency/derogatory status was 6.9 months for filers and 5.8 months for non-filers.

- Consumers who received pre-bankruptcy counseling are more likely to be able to stay current with their accounts.

2.4 Number of open bankcards at or above assigned credit limits

Consumers who received pre-filing counseling had a decrease in the total number of open bankcards with balances at or above their credit limits. Decreases were 62.2% for filers and 66.7% for non-filers.

- Pre-bankruptcy filing counseled consumers appear to exercise more restraint in their use of available credit.

IV. Methodology

1. Data Sources

Three sources of data for the study were used:

- Consumer Data..... Four large credit counseling agencies
- Bankruptcy Data ..... National bankruptcy database
- Credit Bureau Data ..... Experian

	Phase 1	Phase 2
Consumer data		
1. Source	▪ Four large credit counseling agencies across the United States	▪ Same as Phase 1
2. Number of records	▪ 2.7 million consumer records	▪ 322,000 consumer records
3. Use	▪ To identify clients who received counseling and pre-bankruptcy filing counseling from January, 1993 through February, 2008 (Some records fall outside this date range)	▪ To identify clients who received credit counseling and pre-bankruptcy filing counseling between May through July of 2004 and May through July of 2006
Bankruptcy Data		
1. Source	▪ National Bankruptcy Database	▪ Same as Phase 1
2. Number of records	▪ 10.7 MM consumer records	▪ Same as Phase 1
3. Use	▪ To determine if the 2.7 million consumers had filed bankruptcy between 2000 and 2008 ▪ To obtain details of the consumers bankruptcy, if they filed.	▪ Same as Phase 1 ▪ To identify filers who did not receive both pre-bankruptcy filing counseling and pre-discharge counseling (1)
Credit Bureau Data		
1. Source	▪ NA	▪ Experian national database
2. Number of records	▪ NA	▪ Vantage scores and Stagg Variables(2) were provided for: o 322 thousand records from the credit counseling agencies and national bankruptcy database o Data and scores were pulled four times: in 2002, 2004, 2006 and 2008. ▪ 1 million randomly selected consumers for use as a national sample
3. Use	▪ NA	▪ To determine credit scores and credit profile characteristics

(1) Non-counseled clients

- Generally, this group would have received an exception based on extenuating circumstances to have the pre-bankruptcy filing counseling requirement waived.

(2) Vantage Scores℠ and Stagg Variables℠

- In order to assess the impact of credit counseling on the consumer's credit behavior, a national credit bureau (Experian) provided Statistical Aggregates (STAGGS) and credit scores (Vantage Score) for analysis. All personally identifiable information was masked.

- Vantage Score, which is used by lenders and available to consumers, is a credit score developed cooperatively by Experian and the other national credit reporting companies. A total of 130 STAGG variables were reviewed across different trade lines. STAGG attributes can be broadly categorized as follows:

  - Inquiries and Open Accounts (Ability to get new credit)
  - Balances (Credit behavior)
  - Delinquencies and Derogatory (Risk behavior)
  - Consumer demographics (Demographic attributes)

- STAGG variables were available at the consumer level across different trade lines such as mortgage, auto, retail, bankcard, installment, and home equity.

2. Study Approach

The study consisted of:

- Identifying the goal for each of the phases
- Identifying groups of consumers receiving counseling of some type
- Creating control groups to allow comparisons between consumers who received credit counseling and the general population of consumers who have filed for bankruptcy and those who did neither
- Identifying the time period for data collection

	Phase 1	Phase 2
Goal	1) The goal was to provide insight into the effectiveness of **pre and post** BAPCPA programs by examining changes in financial profiles and bankruptcy filing rates	1) The goal was to provide insight into the effectiveness of **post** BAPCPA programs by examining changes in credit profiles and Vantage scores.
Groups Studied	Six groups were created and studied in Phase 1 1) Pre-BAPCPA a) Credit counseling consumers i) Filers ii) Non-filers 2) Post-BAPCPA a) Credit counseling consumers i) Filers ii) Non-filers b) Pre-bankruptcy filing counseling consumers i) Filers ii) Non-filers Filers were further evaluated by [1]: ▪ DMP vs. no-DMP ▪ Chapter 7 vs. Chapter13	Eight groups were created and studied in Phase 2; however, only three which focus on pre-filing bankruptcy counseling are presented in this study 1) Pre-BAPCPA [2] a) Credit counseling consumers i) Filers ii) Non-filers b) Not counseled—NCO [4] 2) Post-BAPCPA [2] a) Credit counseling consumers i) Filers ii) Non-filers b) Pre-bankruptcy filing counseling consumers i) Filers with pre-discharge education. ii) Filers with no pre-discharge education. [3] iii) Non-filers c) NCO [4] i) Filers with pre-discharge education. [3] ii) Filers with no pre-discharge education.

Control group	1) Source for data: a) National bankruptcy database 2) Size of database: a) 10.7 MM consumers 3) Use of data: a) A control group from the national bankruptcy database holding more than 10.7 million consumers was studied to allow a comparison of bankruptcy metrics between consumers who received credit counseling and the general population of consumers who filed for bankruptcy.	1) Source for data: 1 mm a) Experian credit bureau's national database of all US consumers 2) Size of database: 1 mm sub-sampled to 158,000 a) 158,000 consumers matching the credit profile of the pre-bankruptcy filing counseling 3) Use of data: a) Vantage scores and Stagg variables were also provided for a control group of 158,000 consumers with similar creditor profiles as those who received pre-bankruptcy filing counseling. b) Personally identifiable information was removed.
Time Periods	1) The time samples for each of the studied groups were before and after Oct. 17, 2005.	1) Time samples for each of the studied groups were: a) 2 years before filing/counseling (measures the consumer's financial status before counseling and before filing bankruptcy) b) At time of filing/counseling (measures the consumer financial status at the time of counseling/bankruptcy) c) 2 years after filing/counseling (measures the consumer financial status post counseling/bankruptcy)

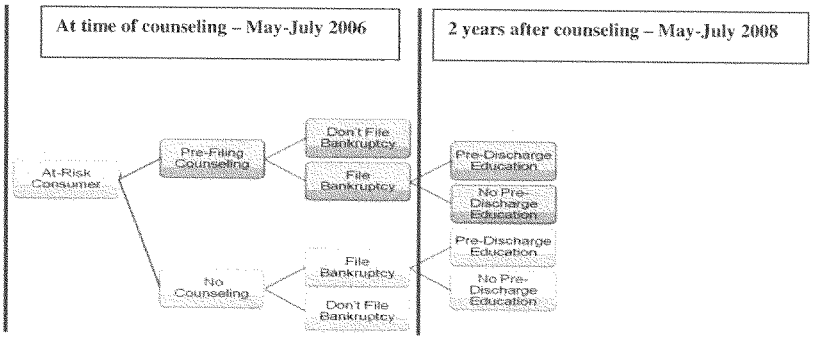
(1) Additional issues that were investigated but not reported in this analysis include:
- Whether the bankruptcy case was eventually dismissed or discharged
- Whether the consumer had filed for bankruptcy before

(2) These groups were evaluated but not included in this study due to the variability of the macro-economic environment.

(3) These groups were not evaluated in this study

(4) NCO—Not counseled consumers
- Not counseled consumers are filers without both pre-bankruptcy filing counseling and pre-discharge education
- To identify consumers who had not received pre-bankruptcy counseling and/or pre-discharge education, bankruptcy case dockets were analyzed.
- Some consumers were given exemptions from either pre-bankruptcy counseling and/or pre-discharge education due to exceptional situations such as Hurricane Katrina. These consumers were therefore included in the non-counseled group. Of the 3,618 cases analyzed, 1,016 cases were from the states of Louisiana and Mississippi where exemptions were granted for all filers due to hardship caused by Hurricane Katrina. These cases were excluded from the analysis.

Figure A: Life-cycle of a Consumer At-risk

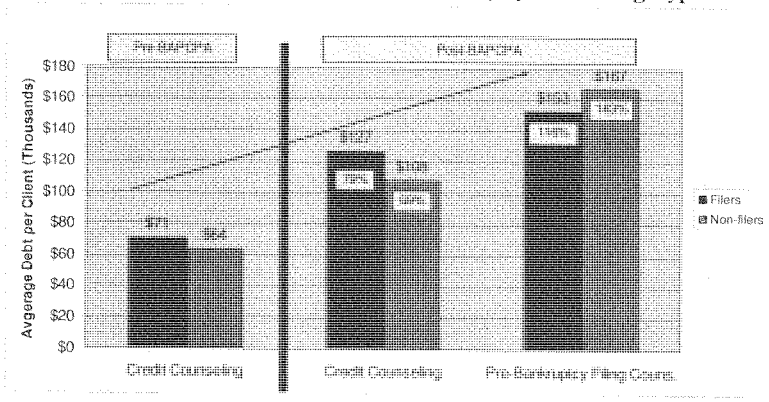


V. Detailed Results for Phase 1

1.1 The average debt per consumer was greater after 2005 than before the enactment of BAPCPA.

a) Filers in 2006 to 2008 had an average debt increase of 79% (from $71,000 to $127,000) for credit counseling consumers and 116% (from $71,000 to $153,000) for pre-bankruptcy filing counseling consumers.
b) Those consumers that did not file bankruptcy had average debt increases of 69% (from $64,000 to $108,000) for credit counseling consumers and 163% (from $64,000 to $167,000) for pre-bankruptcy filing counseling consumers.

Figure 1.1: Average Debt per Client (in thousands) by Counseling Type

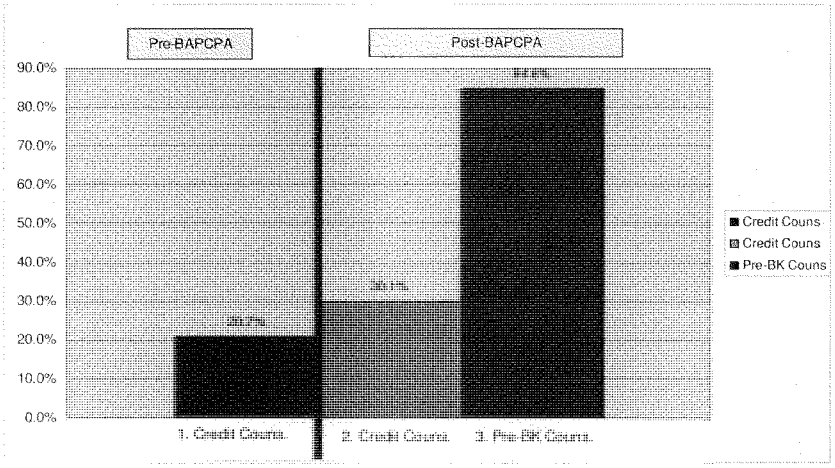


1.2 Filing rates for credit counseling consumers increased from 20.7% pre-BAPCPA to 30.1% post-BAPCPA.

Pre-filing bankruptcy counseling consumers had a filing rate of 84.8%. 15.2% of consumers who completed pre-filing counseling did not file for bankruptcy in the study period.

The increased filing rate can be partially attributed to the larger debt burdens of consumers in post-BAPCPA.

Figure 1.2: Filing Rate by Counseling Type



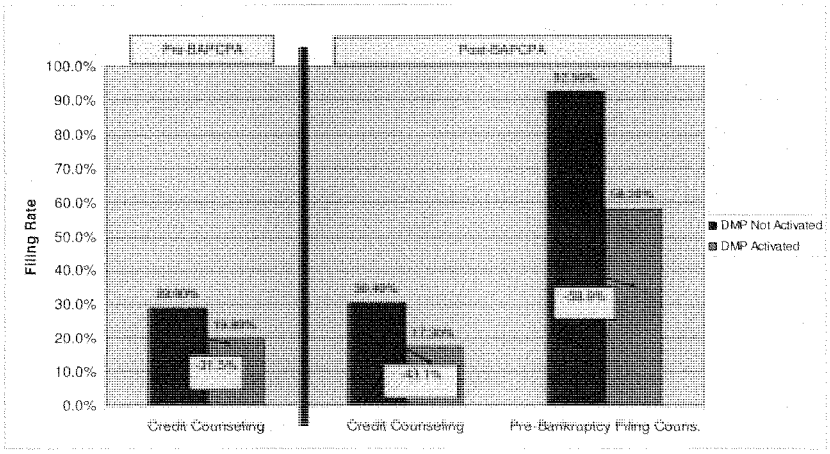
1.3 Consumers who entered a DMP had a significantly lower incidence of bankruptcy filing.

DMPs appear to effectively allow consumers to resolve their financial difficulties without having to file for bankruptcy.

(a) **Prior to 2005**:
- Activation of a DMP decreased the filing rate by **31.5%** (28.9% to 19.8%)

(b) **Between 2006 – 2008**:
- **For credit counseling consumers**:
  - Activation of a DMP decreased the filing rate by **43.1%** (from 30.4% to 17.3%)
- **For pre-bankruptcy filing consumers**:
  - Activation of a DMP decreased the filing rate by **58.9%** (from 92.5% to 58.2%)

Figure 1.3: Impact of DMP Activation on Filing Rate (Pre and Post-BAPCPA)

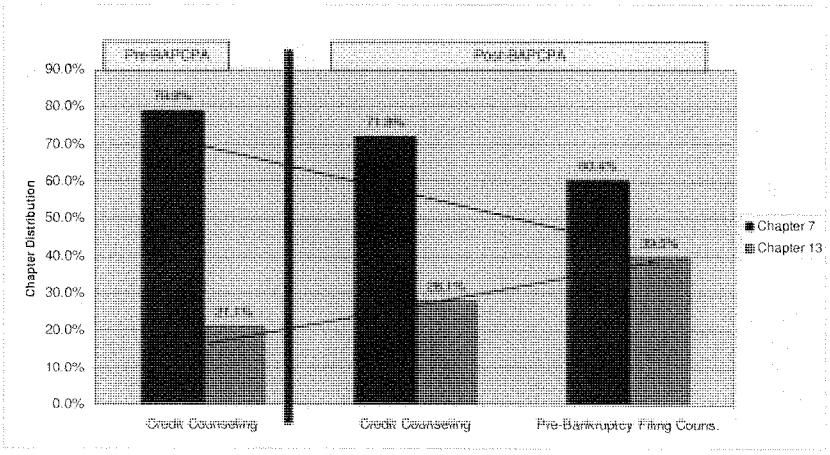


1.4 For those consumers who received credit counseling and subsequently filed for bankruptcy, there was a decrease in the number of Chapter 7 filings and an increase in Chapter 13 filings.

(a) Between 2006 and 2008, Chapter 7 filings decreased from 78.8% to 71.8% for credit counseling consumers and 60.4% for pre-bankruptcy filing counseling consumers.
(b) Between 2006 and 2008, Chapter 13 filings increased from 21.1% to 28.1% for credit counseling and 39.5% for pre-bankruptcy filing counseling.

This finding is consistent with the trends in the national bankruptcy chapter distribution. Of note: many consumers who would have otherwise filed for bankruptcy sometime after October 2005, filed prior to the enactment of BAPCPA causing a temporary shift in Chapter distribution.

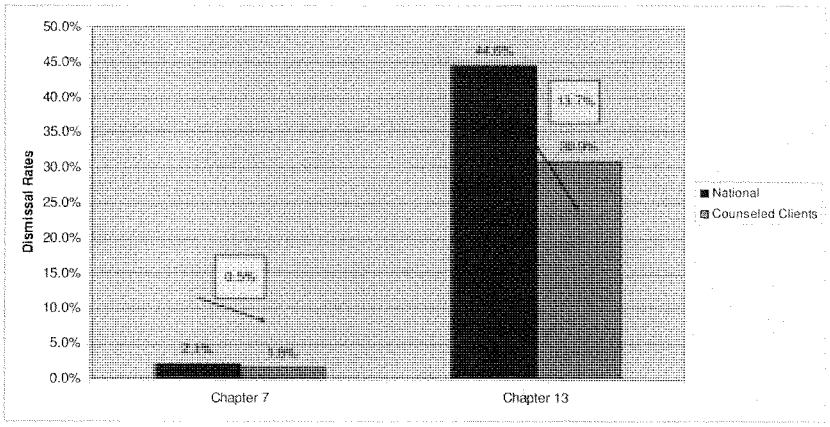
Figure 1.4: Chapter Distribution by Counseling Type



1.5 Credit counseled consumers who filed for bankruptcy had lower dismissal rates in comparison to the national sample for both Chapter 7 (1.6% vs. 2.1 %) and Chapter 13 (30.9% vs. 44.6%) filings.

Credit counseled consumers were more likely to successfully complete the bankruptcy process whether their debts were discharged in a few months through a Chapter 7 bankruptcy or whether they entered a multi-year repayment plan through a Chapter 13 bankruptcy.

Figure 1.5: Dismissal Rates—National vs. Counseled Clients



VII. Detailed Results for Phase 2

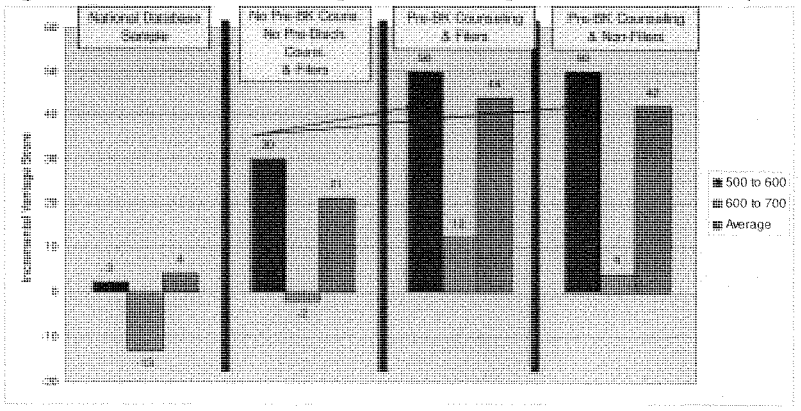
2.1 Part A - The effectiveness of pre-bankruptcy filing is evidenced by a greater improvement in Vantage scores from 2006 to 2008 for counseled consumers.

Vantage scores provide a cumulative snapshot of the consumers' credit behavior. In addition, higher Vantage scores generally allow consumers to access credit at lower interest rates.

(a) **Pre-bankruptcy counseled consumers who filed**
- **In the worst score band (500 to 600):**
  - Improved scores by 50 points from 2006 to 2008.
  - Improved scores 20 points over consumers with no pre-bankruptcy counseling and no pre-discharge education
- **Over all score bands:**
  - Improved average Vantage scores over all bands by 44 points from 2006 to 2008.

b) **Pre-bankruptcy counseled consumers who did <u>not</u> file**
- **In the worst score band (500 to 600):**
  - Improved scores 50 points from 2006 to 2008.
  - Improved scores 20 points over consumers with no pre-bankruptcy counseling and no pre-discharge education
- **Over all score bands:**
  - Improved consumers' average scores over all bands by 42 points from 2006 to 2008.

Figure 2.1 A: Vantage Score Comparison for Groups Included in the Study



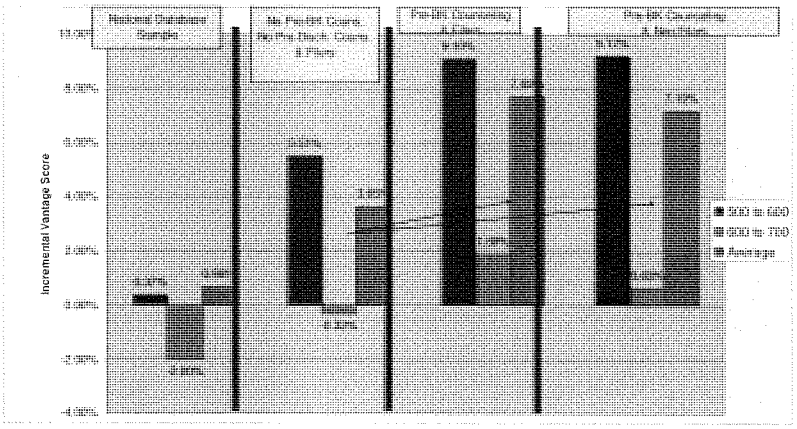
2.1 Part B - The effectiveness of pre-bankruptcy filing is indicated by greater percentage improvements in comparison to other groups in the study

a) Credit scores for pre-filing counseled consumers regardless of chapter filed rose 7.69% versus 3.65% for non-counseled filers.

b) Credit scores for pre-filing counseled consumers who did not file bankruptcy after counseling rose by 7.19%.

c) Credit scores for a national sample with credit profiles similar to those who filed but receiving no counseling and who did not file and were not counseled rose 0.68%

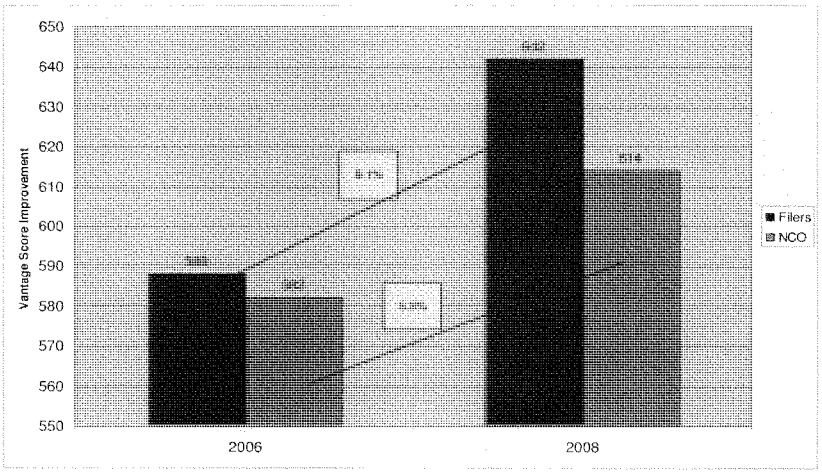
Figure 2.1 B: Vantage Score Comparison for Groups Included in the Study



2.1 Part C - Credit scores for pre-filing counseled consumers filing Chapter 7 rose 9.1% versus 5.5% for non-counseled filers.

Vantage scores for consumers who received counseling, filed Chapter 7and completed the bankruptcy process; displayed a larger improvement in comparison to non-counseled filers.

Figure 2.1 C: Vantage Score Comparison for Chapter 7 Filings



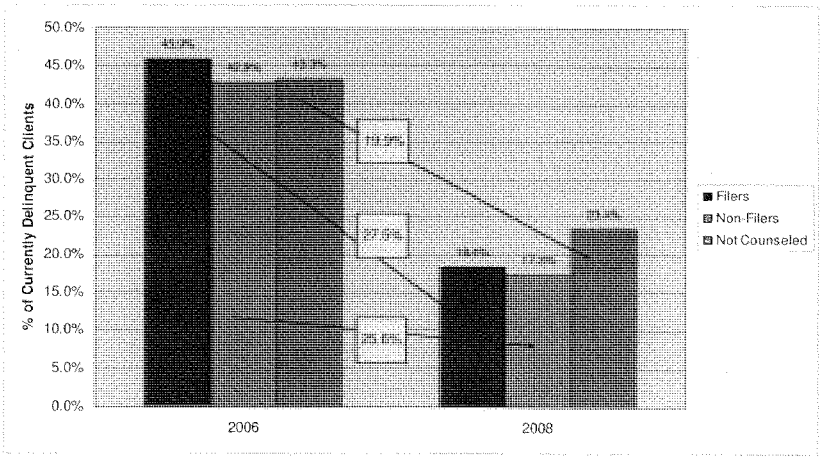
2.2 After bankruptcy, pre-bankruptcy filing counseled consumers had significantly fewer delinquent accounts across all types of credit lines --- a reduction of 27.5% for those that filed bankruptcy and a reduction of 25.6% for those that did not file bankruptcy.

The lower delinquency statuses appear to indicate that consumers who receive pre-bankruptcy filing counseling are better able to manage their credit obligations than those who did not receive counseling.

(a) Pre-bankruptcy filing consumers showed considerable reduction in the number of accounts with delinquency status after 2 years with an overall decrease of 27.5% for filers and 25.6% for non-filers
(b) The non-counseled group (obtained from the national bankruptcy database) only improved by 19.9%
(c) When compared to the non-counseled group, the filers and non-filers performed better by 7.6% (27.5%-19.9%) and 5.7% (25.6%-19.9%)

Note: Delinquency status included 30 to180 days late. Credit lines included: Auto, bankcard, installment, revolving, retail revolving, retail, and home equity.

Figure 2.2: Improvement in Delinquent/Derogatory Accounts from 2006 to 2008



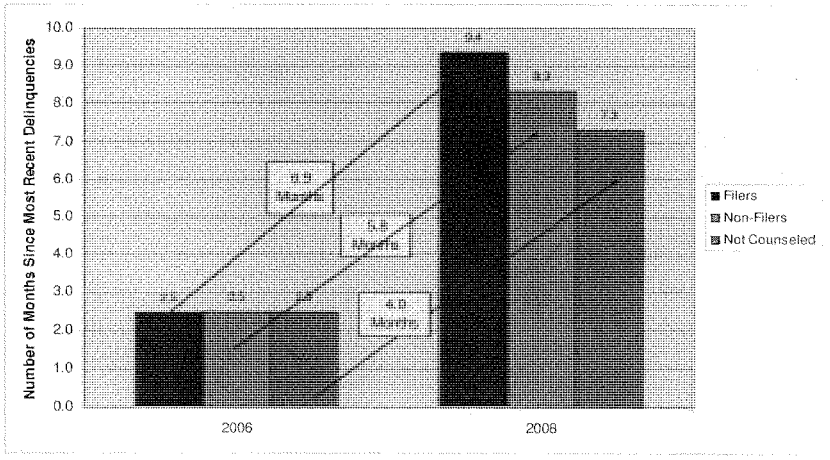
2.3 Consumers who received pre-filing bankruptcy counseling maintained their accounts in a current status for longer periods of time than non counseled consumers. The time between their last delinquency/derogatory status was 6.9 months for filers and 5.8 months for non-filers.

Consumers who received pre-bankruptcy counseling are more likely to be able to stay current with their accounts.

a) Pre-bankruptcy filing consumers showed considerable improvement in the months since last delinquency/derogatory status after 2 years with an overall increase in 6.9 months for filers and 5.8 months for non-filers
b) The non-counseled group (obtained from the national bankruptcy database) only improved by 4.8 months
c) When compared to the non-counseled group, the filers and non-filers performed better by 2.1 months (6.9-4.8) and 1.0 (5.8-4.8)

Note: Delinquency status included 30 to180 days late. Credit lines included: mortgage, auto, retail, bankcard, installment, and home equity.

Figure 2.3: Improvement in Months since last Delinquency/Derogatory from 2006 to 2008



2.4 Consumers who received pre-filing counseling had a decrease in the total number of bankcards with balances at or above their credit limits. Decreases were 62.2% for filers and 66.7% for non-filers

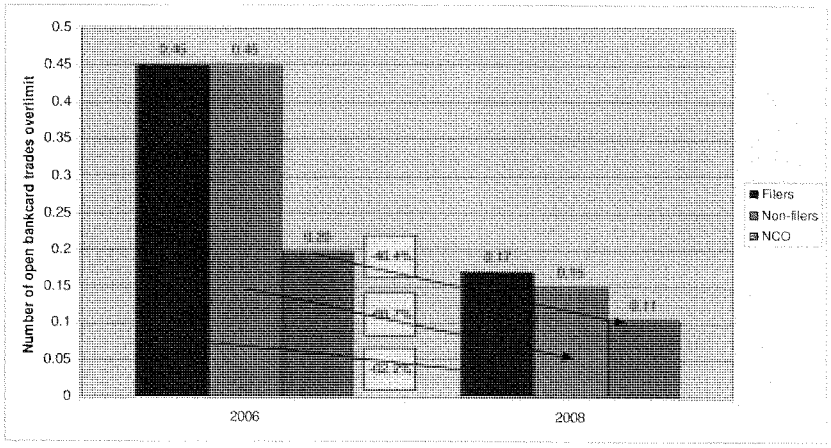
Pre-bankruptcy filing counseled consumers appear to exercise more restraint in their use of available credit.

a) Pre-bankruptcy filing consumers showed considerable improvement in their total number of open bankcards with balance/limit ratio greater than or equal to 100 after 2 years with an overall decrease of 62.2% for filers and 66.7% for non-filers.

b) In addition, the non-counseled group (obtained from the national bankruptcy database) only improved 46.4%

c) When compared to the non-counseled group, the filers and non-filers performed better by 15.8% (62.2%-46.4%) and 20.3% (66.7%-46.4)

Figure 2.4: Improvement in Over Limit Accounts from 2006 to 2008



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Testimony
United States Senate
Committee on the Judiciary
Subcommittee on Administrative Oversight and the Courts

"Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?"

Tuesday, October 20, 2009

John A. E. Pottow,

Professor of Law,

University of Michigan Law School

Introduction

I am a tenured faculty member at the University of Michigan Law School who specializes in bankruptcy and commercial law. I have conducted research into the rising incidence of elder Americans filing for bankruptcy (especially for medical reasons) and on the consequences of the 2005 Bankruptcy Code amendments ("BAPCPA").[1] I have testified previously on these matters before the United States House of Representatives Committee on the Judiciary's Subcommittee on Commercial and Administrative Law at its July 28, 2009 hearing on "Medical Debt: Is Our Healthcare System Bankrupting Americans?"

In the interest of saving time, I incorporate my prior testimony by reference and attach it as an appendix to this new submission. Readers of this testimony would be well advised to read my July testimony first.

My purpose today is to supplement my earlier testimony and to speak in support of proposed S. 1624, the Medical Bankruptcy Fairness Act of 2009.[2] I intend to make two quick but I believe important points. First, lenient treatment of medical debtors in bankruptcy is something on which an emerging scholarly consensus is forming, even for those who cling to the increasingly discredited "means test" of BAPCPA.[3] Second, there is academic support to the perhaps counterintuitive proposition that increasing the amount of nondischargeable debt – that is, making it tougher to discharge certain bills for debtors in bankruptcy – would actually be beneficial to medical (and other) debtors.

Big Picture Agreement: Medical Debtors, Properly Defined, Ought Be Treated Differently under the Bankruptcy Code and Spared Such Burdens as the Means Test's Presumption of Abuse

Scholars seem to agree that exempting medical debtors from onerous bankruptcy requirements is a non-contentious proposition. This was apparent even at the House Subcommittee hearing in July. While there was some disagreement there on how best to define a "medical bankruptcy" amongst the scholars present, there was not, in my recollection, disagreement on the broader principle of providing relief to these people.

BAPCPA was designed to ferret out "deadbeats," who were purportedly abusing the bankruptcy system by discharging debts they incurred through excess consumption that they otherwise had

[1] Bankruptcy Abuse and Consumer Protection Act of 2005, Pub. L. No. 109-0, 119 Stat. 23 (2005).
[2] Medical Bankruptcy Fairness Act of 2009, S. 1624, 111th Cong. (2009).
[3] *See* 11 U.S.C. § 707(b) (2009) (implementing means testing for eligibility to chapter 7 bankruptcy relief). A recent empirical study has cast severe doubt on the efficacy and wisdom of the means test. *See* Robert M. Lawless, Angela K. Littwin, Katherine M. Porter, John A.E. Pottow, Deborah K. Thorne & Elizabeth Warren, *Did Bankruptcy Reform Fail? An Empirical Study of Consumer Debtors*, 82 AMER. BANKR. L.J. 349 (2008).

the ability to repay.[4] BAPCPA was never intended to make life more difficult for people who fell into bankruptcy through no fault of their own but through medically "losing life's lottery."[5] It is therefore unsurprising that scholarly consensus is emerging for the proposition that minimizing the onerous bankruptcy requirements on the least morally blameworthy is sensible.

There of course is some disagreement, as there is in surely many areas in which Congress legislates. The specific one on this topic is the narrower question of just how best to define the "medical debtor" in need of greater relief. That is an issue on which scholars may disagree, but it would be a shame to lose the forest for the trees. Our difficulty in hammering out the details of this narrower definitional question should not eclipse the broader recognition that BAPCPA sweeps too wide a path in catching these medical debtors, however defined. Surely few if anyone would argue that a properly classified medical debtor would gain much by attending a mandatory credit counseling session before filing her bankruptcy petition.[6]

In this regard, the proposed definitions of S. 1624 seem both functional and workable.[7] The alternative definitions (based on, *e.g.*, absolute quantity of medical debt or medical debt as a proportion of income) target plausible criteria and, more importantly to someone who has worked in the bankruptcy trenches, are digestible to practicing attorneys and bankruptcy court judges. Bankruptcy legislation should strive to come up with an accurate definition of the problem being addressed, but it also must be workable within a system that depends upon speed to provide effective relief.

Why do some scholars doubt the prevalence of medical bankruptcies? Some lack the academic freedom of tenure, beholden to directly or covertly partisan groups with pre-determined policy agenda. Some are influenced by industry-funded research. Some are politically result-oriented. But then there are some who have genuine academic skepticism over the methodology of the seminal studies documenting the incidence of medical bankruptcies.[8] It is this last group of scholars I wish to engage.[9]

---

[4] *See, e.g.*, H.R. REP. NO. 109-021 (I), at 92 (2005) ("[A] factor motivating comprehensive reform is that the present bankruptcy system has loopholes and incentives that allow and – sometimes – even encourage opportunistic personal filings and abuse. . . . [S]ome bankruptcy debtors are able to repay a significant portion of their debts . . . .").

[5] I first heard this apt metaphor used in this context by Chairman Cohen at the July subcommittee hearing. I do not know whether he coined it.

[6] The average pre-bankruptcy credit counseling session – mandatory under BAPCPA – costs around $50, as does the additional mandatory in-bankruptcy debtor education session. *See* U.S. GOVERNMENT ACCOUNTABILITY OFFICE, BANKRUPTCY REFORM: DOLLAR COSTS ASSOCIATED WITH THE BANKRUPTCY ABUSE PREVENTION AND CONSUMER PROTECTION ACT OF 2005, 31 (GAO-08-697) [hereinafter GAO REPORT]. The statutory requirements for these counseling sessions is found at 11 U.S.C. §§ 109(h) & 727(a)(11) (2009).

[7] *See* S. 1624, *supra* note 2, § 2(a).

[8] The most recent one that critics have descended upon is David U. Himmelstein, Deborah K. Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MEDICINE 741 (2009) [hereinafter *Harvard Study 2007*]. This builds upon on earlier study: David U. Himmelstein, Elizabeth Warren, Deborah K. Thorne & Steffie Woolhandler, *Illness and Injury as Contributors to Medical*

Let us assume that these scholars have genuine reservations with the higher-end predictions of the medical bankruptcy prevalence of 69%.[10] My response – while being clear that I find the justifications for those higher measures persuasive – is that even if one takes a more crabbed definition of "medical bankruptcy," the estimates are still high. For example, one recent skeptic suggested it could be 27%.[11] If one in four people in financial failure who have to endure the humiliating experience of declaring bankruptcy have found themselves there through no fault of their own other than bad medical luck, that's a terrible indictment of our social safety net. Indeed, if I take just one definition of "medical bankruptcy" (using one close to that proposed by this legislation)[12] – medical debts constituting more than $5,000 or 10% of the debtor's gross income – my data suggest 30% of elderly bankruptcy filers would meet this definition.[13] This is for a population that should be overwhelmingly covered by the Medicare program.[14] Whatever one's preferred metric, the available evidence suggests that "medical bankruptcies" are prevalent and are rising. Surely this trend warrants congressional intervention.

Academics can quibble over the exact percentages and what definitions are best to use, but these are all estimates. Perhaps better evidence comes from those who see the bankruptcy system at work each day. With this in mind, I want to share my anecdotal experience as a still-licensed attorney who frequently interacts with other bankruptcy practitioners and judges in this field. The vast majority of them will tell you that medical reasons are a big cause of filings that they oversee. They will also quickly add that medical reasons are not the exclusive reason. Other reasons abound, from job layoffs, to divorce, to sheer financial irresponsibility – even the most idealistic consumer bankruptcy lawyers I have met admit that more than a few of their clients have overspent beyond their means, plain and simple. But the flip side is I cannot recall offhand any consumer bankruptcy lawyers I have interviewed or met informally who have not mentioned medical reasons as an explanation for a sizeable chunk of their filings.[15] Like global warming, we know it's out there. Even if it's hard to measure, we should do something.

Bankruptcy, HEALTH AFFAIRS (MILLWOOD), February 2, 2005 (web exclusive), *available at* http://content/healthaffairs.org/cgi/reprint/hlthaff.w5.63v1 (last visited July 27, 2009). I explained the misguidedness of these attacks in my prior testimony.

[9] I do this in part to avoid the academic cattiness of having to accuse someone of falling into one of the first three categories.

[10] *See Harvard Study 2007*, supra note 8, at 741.

[11] *See Medical Debt: Is Our Healthcare System Bankrupting Americans?: Hearing Before the Subcomm. on Commercial and Administrative Law of the H. Comm. on the Judiciary*, 111th Cong. 10 (statement of Aparna Mathur, Research Fellow, American Enterprise Institute) (2009). (Dr. Mathur was making this as a generous interpretation of one source of data.)

[12] *See* S. 1624, *supra* note 2, § 2(a).

[13] These data are discussed in my earlier testimony, attached to today's testimony.

[14] Note the proposed definition in S. 1624 would be even more stringent ($10,000 vs. $5,000 threshold). *See* S. 1624, *supra* note 2, § (2)(a), so these numbers will not match up perfectly.

[15] One of the simplest measures of medical bankruptcy is self-report. Of the elder debtors I analyzed and discussed in my July testimony, 33% reported explicitly that medical bills contributed to their bankruptcies and 39% explicitly cited a medical reason of self or spouse as a cause. These reasons are non-exclusive; respondents could answer

Attorney Fee Nondischargeability: A Positive and Sensible Provision

I support this bill's expansion of nondischargeability to encompass pre-petition debts for legal services.[16] This may come as a surprise to some people that the best way to help financially distressed debtors is to decrease the amount of debt they can be relieved of in bankruptcy.

The need to help debtors finance attorney's fees has become particularly acute after BAPCPA, because the level of those fees rose dramatically. As documented in a GAO Report just last year, fees for attorneys in both chapter 7 and chapter 13 bankruptcies have risen (as predicted) around 50%.[17] The run-up in costs is associated with the deluge of new paperwork required by BAPCPA – costs that this bill would help minimize by exempting medical debtors from means testing. Indeed, one reason BAPCPA may have reduced the number of filers for bankruptcy may be increased attorney's fees pricing some debtors out of the "bankruptcy market" by being unable to afford representation. (Note that these debtors do not seem to go it alone by filing pro se – data in the same GAO study report that the number of pro se filers actually decreased after BAPCPA,[18] which is not surprising given the incredible complexity the statute created for bankruptcy filers. It is hard enough for a seasoned bankruptcy attorney to figure out the statutory quagmire; one recent study found 77% of lawyers spending 50% more time on bankruptcy filings post-BAPCPA and 27% spending 100% more time.[19] The prospects for a pro se filer to navigate these waters successfully unassisted are slim.)

As indicated, some debtors responded to this increase in attorney's fees by simply giving up, unable to afford representation altogether, which was surely not the goal of BAPCPA (at least the stated goal of BAPCPA championed by its supporters – the cynical might suggest this was an implicit goal all along).[20] Another approach has been to finance attorney's fees through electing

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both affirmatively. (Note that some critics disparage the non-exclusive choices of this survey instrument as an impediment rather than an advantage. They are misguided. Whether someone ascribes his bankruptcy to a medical reason and a mortgage foreclosure does not undermine the finding that medical causes contributed, at least in part, and in significant enough part for the respondent to ascribe a causal role, to the financial collapse. The methodological alternative these critics implicitly prefer – asking the subject to allocate causation proportionally – is the sort of operationally implausible approach only one who has never conducted field research could love.)

[16] *See* S. 1654, *supra* note 2, § 6.

[17] *See* GAO REPORT, *supra* note 6, at 21 et seq. Professor Robert Lawless at the University of Illinois Law School also collects data on this.

[18] *See id.* at 27-28.

[19] *See* Steve Seidenberg, *Strange New World: Lawyers, Debtors and Creditors Are Struggling to Absorb Sweeping Changes in Bankruptcy Law*, 93 A.B.A. J. 48 (2007) (reporting findings of National Association of Consumer Bankruptcy Attorneys survey).

[20] *See, e.g.*, James J. White, *Abuse Prevention 2005*, 71 MO. L. REV. 863, 874 (2006) ("By raising the costs in hundreds of little ways, you might make bankruptcy unpalatable to many who currently take bankruptcy. . . . Nor would you be obliged to admit that the true reason for advocating these bureaucratic changes was to degrade the machinery of bankruptcy.").

chapter 13 even though a debtor is otherwise eligible and appropriate for chapter 7 relief, thus raising the number of "unnecessary" chapter 13s.[21] While it is difficult to collect "hard" quantitative evidence of this trend – there is no form to complete in the bankruptcy petitioner's schedules indicating whether a chapter 13 filing is solely to extend the repayment period to his attorney – it is believed to be a not infrequent phenomenon by members of the bankruptcy community. In fact, in a RAND study commissioned by the Department of Justice published in 2007, focus groups of bankruptcy system participants explored among other questions why there were so many chapter 13 filings – three-quarters by the study's estimate – by below-median-income debtors (*i.e.*, debtors who bypass the means test automatically by virtue of their below-median incomes and hence can choose whether to file chapter 7 or 13). There were a number of reasons, including home retention, preservation of secured debt collateral, a moral desire to pay creditors off over several years, and different local legal cultures. But one of the key reasons cited by many respondents was a desire to afford attorney's fees by being able to stretch them out over the course of the chapter 13 plan of three-to-five years.[22]

The reason for making these attorney's fees nondischargeable stems from straightforward economic reasoning: if a lender knows its debt will be dischargeable in bankruptcy, it is likely either to (1) make the cost of that debt more expensive to account for this write-off risk (charge a "premium" in economics parlance) or (2) not make the loan in the first place ("ration" the good, to an economist). Thus, by making the attorney's bill non-dischargeable, a putative lawyer will feel more comfortable taking on a client's case without demanding upfront payment.[23]

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[21] A chapter 13 plan ordinarily takes between three and five years to complete. Accrued attorney's fees are generally paid out as claims over the course of the plan and are accorded priority, which means that the debtor must pay 100% of the claim. *See* 11 U.S.C. § 1322(a)(2) (2009). By contrast, debtor's attorney's fees are not accorded priority in chapter 7. Given that 95% of chapter 7 plans distribute no assets to creditors, *see* GAO REPORT, *supra* note 6, at 37, 95% of chapter 7 attorneys who extended credit to the debtor could expect to see their invoices discharged in the very bankruptcy they are helping to conduct. This is why most chapter 7 attorneys insist upon up-front cash payments for all or at least some of their fees before rendering service. *See generally* Jean Braucher, *Lawyers and Consumer Bankruptcy: One Code, Many Cultures*, 67 AM. BANKR. L.J. 501, 547-49 (1994) (discussing pre-BAPCPA and pre-*Lamie* billing practice and actually noting that lawyers used to allow at least some credit even in chapter 7 cases, varying by region).

The comparatively favorable treatment of attorney's fees in chapter 13 vs. chapter 7 was exacerbated by the Supreme Court's "mistaken" interpretation of 11 U.S.C. § 330 to deny chapter 7 attorney's fees priority. *See* Lamie v. United States Trustee, 540 U.S. 526 (2004). I use quotation marks, because the Supreme Court, of course, renders authoritative pronouncements interpreting the Bankruptcy Code (or any law) and so cannot be "mistaken" in a legal interpretation—as a matter of law (literally) – but the decision was largely viewed by bankruptcy scholars and practitioners as flubbing the issue. (My grapes may be extra sour; I was co-counsel for the loser, but I am far from a lone voice in my criticism. *See, e.g.*, Dillon E. Jackson, *Lamenting Lamie and the Appointment of the Chapter 11 Trustee*, 23 AMER. BANKR. INST. L. J. 28 (November, 2004).)

[22] *See* U.S. DEPT. OF JUSTICE, EXECUTIVE OFFICE FOR UNITED STATES TRUSTEES, REPORT TO CONGRESS: IMPACT OF THE UTILIZATION OF INTERNAL REVENUE SERVICE STANDARDS FOR DETERMINING EXPENSES ON DEBTORS AND THE COURT, at 24, 42 (2007).

[23] Of course, like any economic proposition, the reasoning can be carried to absurd extreme (a fault many economists fall victim to when enticed by the analytic simplicity of a proposition). To ridicule the position, I could suggest that to help consumers the most, we should allow draconian punishments for non-payment of debt, such as permitting creditors to excise a pound of flesh, to usher in the cheapest interest rates of all! *See* John A. E.

Accordingly, we have academic evidence both that BAPCPA has driven up the costs of legal representation in bankruptcy and that at least some debtors cannot afford the (presumably increased) upfront cash payment traditionally associated with chapter 7 representation. As such, some proportion of chapter 13 petitions are being filed "unnecessarily" – for no reason other than to help a debtor hire a lawyer and ensure the lawyer that she will be paid. We also have economic theory positing that making the attorney's fees nondischargeable will make the cash-demanding chapter 7 attorneys more comfortable extending more or all of their legal services on credit. Taken together, these points suggest nondischargeability would be a positive development for debtors. Ensuring that chapter 7 attorneys will be paid (more precisely, increasing the likelihood they will be paid because their debts will be unaffected by the bankruptcy discharge) will increase access to chapter 7 legal relief. This will have the joint effect of helping all debtors and making the grant of broader chapter 7 eligibility implemented by S. 1624 all the more efficacious.

One important qualification is in order. Nondischargeability accords significant leverage over the debtor by the favored creditor; its grant should be specifically justified and its application carefully policed.[24] I might worry about the danger of a less sophisticated debtor being over-charged by an attorney and then having to pay off that undischarged debt after bankruptcy. Fortunately, the Bankruptcy Code already has special provisions designed to police the compensation of attorneys, including 11 U.S.C. § 329(a) and Fed. R. Bankr. P. 2016(b).[25] These include rules requiring disclosure of fees imposed by attorneys within one year of filing. It might be helpful to include a specific cross-reference to these statutory provisions in the bill's nondischargeability section to remind counsel and courts of the importance of judicial oversight of these now-nondischargeable attorney's fees.[26] Indeed, one form of vigilance that may emerge is the practice similar to chapter 13 fee policing of establishing so-called "no look" rules within judicial districts, whereby fees submitted under a certain threshold are deemed approved automatically.[27] Accordingly, as long as this important caveat is kept in mind, the nondischargeability rule seems eminently sensible.

Pottow, *The Nondischargeability of Student Loans in Personal Bankruptcy Proceedings: The Search for a Theory*, 44 CAN. B. L. J. 211, 262 n. 73 (2006) (discussing *The Merchant of Venice*). We of course don't do this, for a variety of deontological and consequentialist reasons beyond the scope of this testimony.

[24] *See generally* Pottow, *supra* note 23, *passim*.

[25] *See also* 11 U.S.C. §§ 327-330 (2009) (pertaining to attorney retention, oversight, and compensation).

[26] At the risk of getting too technical, drafters of this bill may want to consider whether chapter 13 (or 12) attorney's fees ought to be nondischargeable as well, or whether their current entitlement to priority suffices. There is also the issue of unpaid chapter 13 attorney's fees accrued but not yet paid prior to conversion to a chapter 7 case.

[27] A helpful discussion of this practice can be found in the already mentioned GAO Report. *See* GAO REPORT, *supra* note 6, at 24-27.

Conclusion

Medical bankruptcies continue to grow. They are not just a problem, they are a growing problem. As I have testified elsewhere, while much of the desired solution probably involves deep structural changes to our healthcare system – reform that this Congress is already bravely confronting – modifications within the Bankruptcy Code itself can be made to help incrementally. The proposed bill considered by this committee is sound. It cannot eliminate medical bankruptcies, but it can reduce the burden that the bankruptcy system imposes on unfortunate debtors who have lost life's lottery in suffering serious medical setbacks that have dragged them into financial disaster. These people are not the "deadbeats" BAPCPA was supposed to weed out with its means test, and so exempting them from the means test's application seems not only efficient in terms of cost-savings but morally just. Similarly, preventing useless credit counseling that serves little purpose for these people other than adding costs also makes sense. Finally, increasing the chances these debtors can find affordable representation to navigate the daunting labyrinth of the Bankruptcy Code is yet another step in the right direction. I strongly urge the adoption of S. 1624 and wish the Congress luck in its broader healthcare deliberations.

Attach. (July 28, 2009 Testimony of Prof. John A.E. Pottow)

Appendix

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

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

Tuesday, July 28, 2009

John A. E. Pottow,
Professor of Law,
University of Michigan Law School

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

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

Methodology of the Consumer Bankruptcy Project[1]

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

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

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

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

for medical expenses. None of these finer-grained insights are ascertainable by court records alone; studies that purport to offer insight on medical bankruptcies without such disaggregation are of limited utility.

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

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

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

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

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

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

$100,000, or $1,000,000. But they miss the point: what good researchers try to do with statistics is estimate naturally immeasurable "noumenal" realities.[6] Dr. Woolhandler should not be faulted with proffering alternative definitions of a "medical bankruptcy"; she should be applauded.

Elder Americans in Crisis

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

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

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

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

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

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

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

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

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

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

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

Bankruptcy Law

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

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

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

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

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

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

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

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

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

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

save medical debtors by rebutting the means test's presumption of abuse.

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

Proposals

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

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

The broader question, of course, taking off my bankruptcy hat, is what reforms "upstream" could help these people before they even go bankrupt? Here I draw attention to a recent study suggesting that at least 32-49% of home-losers ascribed their mortgage foreclosures to a medical

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

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

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

cause (without even necessarily filing for bankruptcy).[18] That question I defer to Congress. It would appear given how fast the ranks of the bankrupt are increasing with medical debtors that something desperately needs to be done. Whether that is more health insurance, better coverage in Medicare, or a single-payer-style system, I leave to those more expert – and more elected – than I. Again, I am just the bearer of bad news regarding the increasing incidence of medically related bankruptcy filings and its special impact on elderly Americans.

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

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

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GET SICK, GET OUT: THE MEDICAL CAUSES OF HOME MORTGAGE FORECLOSURES

Christopher Tarver Robertson, Richard Egelhof, & Michael Hoke[*‡]

INTRODUCTION AND SUMMARY

In recent years, there has been national alarm about the rising rate of home foreclosures, which now strike one in every 92 households in America, and which contribute to even broader macroeconomic effects.[1] The handy explanation for the rise in foreclosures is that irresponsible borrowers have been using exotic loan products to purchase homes they cannot in reality afford.[2] Moreover, these buyers allegedly

[*] Please direct correspondence to Christopher Tarver Robertson at crobertson@post.harvard.edu. The authors thank Elizabeth Warren for extensive advice and guidance on this project. We also thank Dean Elena Kagan for generously funding the project; Einer Elhauge and the Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics for financial support; Kimberly Breger, Roger Bertling, Michael Collins, Deborah Thorne, Katherine Porter, Ken Carson, Heidi Williams, and the Fellows of the Petrie Flom Center for providing insights at various stages of the project; and Kathy Paras, Kathy Goldstein and especially Jane Wagner for extensive administrative support. We also thank the many Harvard Law School students who assembled the survey packages and called those who had not yet responded.

[‡] All survey data referenced in this article is on file with the authors. Please direct inquiries regarding survey data to Christopher Tarver Robertson at crobertson@post.harvard.edu.

[1] Press Release, RealtyTrac, More Than 1.2 Million Foreclosure Filings Reported in 2006 (Jan. 25, 2007), http://www.realtytrac.com/ContentManagement/pressrelease.aspx?ChannelID=9&ItemID=1855&accnt=64847 (stating that foreclosure struck 1 in 92 households in 2006); Associated Press, *Early Gains Give Way to Small Loss*, N.Y. TIMES, Aug. 14, 2007, at C4 ("Defaults among subprime mortgage holders — borrowers with weak credit — began the chain of events that led to the turmoil on Wall Street and other stock markets in recent weeks."); *See* David Cho, *Huge Mortgage Lender Files for Bankruptcy*, WASH. POST, Apr. 3, 2007, at A1.

[2] *See Home Wreckers: Who Is To Blame For America's Soaring Mortgage Foreclosure Rate?* CHICAGO SUN TIMES, Mar. 18, 2007, at B2 ("Last week, the Mortgage Bankers Association reported that mortgage foreclosures hit a record high, and late mortgage payments hit a 3-year high. The culprits? Risky, nontraditional loans, high interest rates, unworthy borrowers and predatory lenders in the 'subprime mar-

relied on optimistic projections for the housing market, and low interest rates, which have not panned out.[3] Commentators have also pointed to lax lending standards and aggressive practices by brokers as contributing to the increase of high-risk, non-traditional loans that are more likely to foreclose.[4] These factors – loose lending, irresponsible borrowers, a flat real estate market, and rising interest rates – have together become the "standard account" of home foreclosure.

Policymakers and scholars may be surprised to learn that even in the midst of this spike, one of the largest causes of home foreclosures was none of the above. We studied homeowners going through foreclosure in four states and found that medical crises contribute to half of all home foreclosure filings. If these patterns hold nationwide, medical causes may put as many as 1.5 million Americans in jeopardy of losing their homes each year.[5] If these findings are accurate, they help

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ket.'"); David Streitfeld, *The Mortgage Meltdown: Foreclosure Pace Nears Record High*, L.A. TIMES, Apr. 17, 2007, at C1 ("Most of the loans going into default now were made at the peak of the housing boom in 2005, when some thought the good times would continue forever and lending standards were lax. Nearly 80% . . . had adjustable rates, a record high. Many of these mortgages required the borrowers to put little or no money down, and lenders took their word for whatever income they said they made. For a moment, everything was fine. Then housing prices stopped going up – meaning that many of these borrowers did not have enough equity or income to refinance to a new loan. Others in foreclosure may be able to afford the payments, but have chosen not to make them because their homes are worth less than they paid."); *Alternative Mortgage Products: Testimony Before the Subcomms. on Housing and Transportation and Economic Policy, S. Comm. on Banking, Housing, and Urban Affairs*, 109th Cong. 1, 7 (2006) [hereinafter *Alternative Mortgage Products*] (statement of Orice M. Williams, Director, Financial Markets and Community Investments), *available at* http://banking.senate.gov/_files/ACF84D8.pdf (describing the increasing incidence of alternative mortgage products (AMPs) that allow buyers "to purchase homes that might otherwise be unaffordable").

[3] *See supra* note 2 and accompanying text. This account is consistent with the "option theory" of mortgage default in the scholarly literature. *See infra* notes 39-43 and accompanying text.

[4] *See* Streitfeld *supra* note 2; *Alternative Mortgage Products*, *supra* note 2, at 9 ("[S]ome lenders combined AMPs with less stringent income and asset verification requirements than traditionally permitted for these products or lent to borrowers with lower credit scores and higher debt-to-income ratios."); JOINT ECON. COMM., 110TH CONG., SHELTERING NEIGHBORHOODS FROM THE SUBPRIME FORECLOSURE STORM 1 (Apr. 11, 2007), *available at* http://www.jec.senate.gov/Documents/Reports/subprime11apr2007revised.pdf (Sen. Charles E. Schumer, Chairman of the Joint Economic Committee, issued this special report that declared, "Over the past several months, it has become increasingly clear that irresponsible subprime lending practices have been contributing to a wave of foreclosures that are hitting homeowners and rattling the housing markets.").

[5] *See* Press Release, RealtyTrac, *supra* note 1; U.S. Census Bureau, Households and Families: 2000, http://factfinder.census.gov/servlet/QTTable?_bm=y&-geo_id=01000US&-qr_name=DEC_2000_SF1_U_QTP10&-

explain the bulk of home foreclosures, which have been occurring with stubborn frequency for a quarter century.[6]

From the social policy perspective, it is critical that we get the story straight, as mortgage foreclosure may be one of the most significant legal devices, striking millions of Americans,[7] with dramatic consequences for each one. For individuals, the purchase of a home is often the largest financial decision they ever make, and the transaction costs of getting into, and then out of, a mortgage can be onerous. Indeed, foreclosure can wipe out the homeowners' savings and leave them owing debt on homes they no longer own.[8] A foreclosure also has pernicious effects for the borrowers' families, neighborhoods, and local communities.[9] Foreclosures are expensive for lenders, reducing returns to investors in the secondary mortgage market and increasing costs to borrowers *ex ante*.[10] Finally, foreclosures frustrate the national goal of home ownership.[11]

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ds_name=DEC_2000_SF1_U (last visited Oct. 11, 2007) (noting Table QT-P10 lists the average household size as 2.59). The 1.2 million foreclosures multiplied by an average household size of 2.59, yields 3.108 million persons who were subject to foreclosure filings. The 1.5 million figured is derived by multiplying 3.108 million by 49%, which is the percentage of respondents in our study who self-identify as having one of the four core medical causes. *See infra* Part IV. There is some controversy over the RealtyTrac numbers. *See* Greta Guest, "RealtyTrac Data Disputed", DETROIT FREE PRESS, available at http://www.freep.com/apps/pbcs.dll/article?AID=/20070723/BUSINESS04/707230357/1002/BUSINESS (July 23, 2007) (critics, including the Mortgage Bankers Association, argue that RealtyTrac's numbers are inflated due to counting multiple filings for the same property).

[6] *See, e.g.*, U.S. DEP'T OF HOUS. & URBAN DEV., PROVIDING ALTERNATIVES TO MORTGAGE FORECLOSURE: A REPORT TO CONGRESS, at vii (1996), *available at* http://www.huduser.org/publications/hsgfin/mortgage.html ("The percentage of U.S. homeowners with serious delinquency problems has been at chronic levels since 1983. . . . On the dark side, the statistics of the past 15 years represent 3 million American families who not only faced the financial and emotional specter of being forced from their homes, but who also suffered loss of access to credit.").

[7] *See* calculations *supra* note 5.

[8] Michael H. Schill, *An Economic Analysis of Mortgagor Protection Laws*, 77 VA. L. REV. 489, 493-94 (1991) ("One of the primary objectives of mortgage foreclosure law is to have the sheriff, judge, or trustee sell the property for a price that equals its fair market value. For several reasons, however, this rarely occurs. . . . When the foreclosure sale price is less than the debt owed to the mortgagee, the mortgagee may proceed against the borrower for a deficiency judgment in the amount of the shortfall if the terms of the loan allow such an action.").

[9] *See* JOINT ECON. COMM., *supra* note 4, at 16 (citing studies that show every new home foreclosure can cost stakeholders up to $80,000, when adding up the costs to homeowners ($7,200), lenders ($50,000), neighbors ($1,508), and local governments ($19,227)).

[10] *See* Desiree Hatcher, *Foreclosure Alternatives: A Case for Preserving Homeownership*, PROFITWISE NEWS AND VIEWS, Feb. 2006, at 2, 2 (in 2003, lenders

To explore the causes of home foreclosure, we conducted a survey of homeowners on the brink of foreclosure, those who have (allegedly) defaulted on their loans and whose lenders have initiated legal foreclosure proceedings.[12] Most fundamentally, we simply asked homeowners what factors contributed to their defaults, but we supplemented this data with additional questions about their objective situations and with publicly-accessible data about their homes.

This preliminary study reveals that the standard account is, at best, an inadequate understanding of the causes of mortgage defaults.[13] We found homeowners that tended to have significant equity in their homes and reasonable ratios between their income and their mortgage debt burdens. Few reported that their loans were unaffordable and only about a third said increasing mortgage payments were a factor in their defaults. From the surface, these respondents appear to be able to afford their homes and have no reason to walk away from them. So why are they in default?

Our evidence suggests that medical disruptions are a major contributor to mortgage default, often striking in combination with other factors. Half of all respondents (49%) indicated that their foreclosure was *caused* in part by a medical problem, including illness or injuries (32%), unmanageable medical bills (23%), lost work due to a medical problem (27%), or caring for sick family members (14%). We also examined objective indicia of medical disruptions in the previous two years, including those respondents paying more than $2,000 of medical bills out of pocket (37%), those losing two or more weeks of work because of injury or illness (30%), those currently disabled and unable to work (8%), and those who used their home equity to pay medical bills (13%). Altogether, we found that about 7 in 10 of our respondents either self-reported a medical cause of foreclosure, or experienced one of these indicia of medical disruptions in the years before foreclosure. In many cases, homeowners were hit with a perfect storm of factors – a few thousand dollars of medical bills, a few weeks of

incurred approximately $25 billion in foreclosure-related costs).

[11] *See* I.R.C. § 163(h)(2)(D) (2000) (allowing deduction from taxable income of interest paid on acquisition and home equity indebtedness on a qualified residence, which effectively reduces the interest rate on the mortgage by as much as the taxpayer's marginal federal income tax rate); J. COMM. ON TAX'N, SELECTED DATA RELATED TO THE FEDERAL TAX SYSTEM, JCX-11-07, at 8 tbl.5 (2007), *available at* http://www.house.gov/jct/x-11-07.pdf (The mortgage interest deduction will cost the Federal government $402.7 billion over the five-year period from 2006 to 2010).

[12] *See infra* Part II for a full discussion of the research methodology.

[13] *See infra* Part III for a full discussion of the findings.

missed work, and perhaps a divorce or rising interest rate – all combined to push them over the edge into foreclosure.

Our findings provide a more textured account of the reality of home foreclosure, and provide new evidence of middle class financial insecurity. If these findings can be replicated by more comprehensive future studies, they will suggest broad policy reforms and reassessment of the narrowly-focused legal regime that lenders use to facilitate foreclosures. In addition to the current focus on structural adjustments, which force people out of homes they cannot afford, policymakers should consider insurance-related interventions, which could help homeowners bridge temporary difficulties caused by medical crises. We also present a legal proposal for staying foreclosure proceedings during verifiable medical crises, as a way to protect homeowners and to minimize the negative externalities of foreclosure.

We begin in Section I by providing a primer on foreclosure law and a review of some of the literature on financial distress. In Section II, we outline our research methodology, and we present our results in Section III. We conclude with some thoughts on policy reforms and future research possibilities.

I. FORECLOSURE LAW AND THE LITERATURE ON FINANCIAL DISTRESS

In general terms, a mortgage foreclosure occurs when a borrower breaches the contract with his or her lender, who then invokes state laws that culminate in the sale of the property in order to recoup at least some of the balance on the loan.[14] Although all states allow a lender to bring an action in court that would lead to such an eventual sale, most states allow for a lender to sell the property without involving a court whatsoever, as long as the borrower agreed to such a procedure in the loan contract *ex ante*.[15] We chose the four states we surveyed – Florida, New Jersey, California and Illinois -- in part to reflect a diversity of state law foreclosure proceedings, and to ensure that there would be enough time for the surveys to reach participants before their homes were sold. See Table 1.

[14] *See* Debra Pogrund Stark, *Facing the Facts: An Empirical Study of the Fairness and Efficiency of Foreclosures and a Proposal for Reform*, 30 U. MICH. J.L. REFORM 639, 643 (1997) (explaining the consequences of defaulting on mortgage payments and discussing the basic features in statutory schemes of state foreclosure laws). See Karen M. Pence, *Foreclosing on Opportunity: State Laws and Mortgage Credit*, 88 REV. ECON. & STAT. 177 (2006), for a complete discussion on the relationship between state law and foreclosure.

[15] Schill, *supra* note 8, at 492-93.

Table 1: Summary of Foreclosure Laws By State

	Primary Type	Time to Conclusion	Must Pay Accelerated Debt to Reinstate?
California	Non-judicial	Up to 4 months	No
Florida	Judicial	4 to 6 months	Yes
Illinois	Judicial	9 months to 2 years	No
New Jersey	Judicial	8 to 12 months	No

Foreclosures in California can be either judicial or non-judicial.[16] A judicial foreclosure is required if the mortgagee seeks a deficiency judgment, but the process is slower and more costly than non-judicial foreclosure.[17] When the mortgagee uses judicial foreclosure to seek a deficiency, the mortgagor receives a right of redemption effective for one year following sale, which does not exist for non-judicial foreclosures.[18] For these reasons, almost all mortgage foreclosures are non-judicial, and typically take less than four months.[19] Under California law, a mortgagee must file a notice of default with the county recorder, who mails the affected parties at least 110 days before the sale, and notice of the sale must be published at least 20 days before the sale.[20] The mortgagor has a right to reinstate his mortgage up until five days before the sale by paying the amount in default plus costs associated with foreclosure.[21] Although most mortgage contracts include an "acceleration clause" whereby the entire amount of the mortgage comes due upon default, in California, the mortgagor is not required to pay

[16] MICHAEL T. MADISON, JEFFREY R. DWYER & STEVEN W. BENDER, THE LAW OF REAL ESTATE FINANCING § 17:9.

[17] A deficiency judgment is a claim against the borrower personally for the unsecured portion of the debt, which remains after the collateral exhausted.

[18] CAL. CIV. CODE § 726(e) (West Supp. 2007).

[19] ANDREA LEE NEGRONI, JOHN P. KROMER & MARY M. PFAFF, RESIDENTIAL MORTGAGE LENDING: STATE REGULATION MANUAL WEST, CALIFORNIA MORTGAGE LENDING § 2:19 (Aug. 2007) *available at* RML-SRW CA s 2:19 (Westlaw).

[20] CAL. CIV. CODE §§ 2924(a), 2924f (West 1993 & Supp. 2007).

[21] §§ 2924c(a), (e).

the accelerated debt in order to reinstate the mortgage. All foreclosures in Florida are accomplished through judicial proceedings without a jury,[22] and usually take three to six months.[23] There is no notice required prior to the filing of court proceedings, but the court may require that the lender effectuate personal service on the borrower.[24] The sale of property usually occurs between twenty to thirty-five days following judgment.[25] Generally, the mortgagor has a right to redeem the property any time before the filing of a certificate of sale by paying the entire amount due under the judgment or under the security interest plus any other amounts due including acceleration and costs including attorney's fees.[26] Otherwise there is no right of redemption.[27]

All foreclosures in Illinois occur through judicial proceedings,[28] and usually take nine months, but can take up to two years if a mortgagor mounts a defense.[29] For three months after receiving a foreclosure notice, a mortgagor can prevent foreclosure through reinstatement by curing all defaults.[30] For this right to be invoked, the mortgagor does not have to pay any accelerated indebtedness, but must pay the portion of the principal that was due at the time of the default plus additional accumulated expenses needed to make the account current.[31] A residential homeowner also has a right of redemption for

[22] FLA. STAT. ANN. § 702.01 (West 1994).

[23] MADISON ET AL. *supra* note 16 at § 20:2.

[24] "The requirement of personal service on the borrower sometimes entails extraordinary efforts to locate the borrower." ANDREA LEE NEGRONI, ET AL., RESIDENTIAL MORTGAGE LENDING: STATE REGULATION MANUAL SOUTH EASTERN, FLORIDA MORTGAGE LENDING, § 2:19 (Nov. 2007), *available at* RML-SRSE FL s 2:19 (Westlaw).

[25] Although Florida law does not mandate any procedure, it does provide a procedure that can be used, and courts generally follow those procedures. FLA. STAT. ANN. §§ 45.031 (West 2006). *See* MADISON ET AL *supra* note 16 at § 20:2.

[26] § 45.0315.

[27] NEGRONI, ET AL., *supra* note 19 at § 2:19.

[28] Illinois Mortgage Foreclosure Law, 735 ILL. COMP. STAT. ANN. 5/15-1102 (West 2003). In certain circumstances where the lenders are willing to forgo a deficiency judgment claim and the mortgagor waives her rights to reinstatement and redemption, a mortgagee and mortgagor can agree to a "consent foreclosure" which accelerates the process. *See* 735 ILL. COMP. STAT. ANN. § 5/15-1402 (West 2003).

[29] *See generally* Illinois Mortgage Foreclosure Law, 735 ILL. COMP. STAT. ANN. 5/15-1101 to -1706 (West 2003); ILLINOIS ATTORNEY DESK REFERENCE MANUAL, HOUSING LAW: MORTGAGE FORECLOSURE (2003), *available at* http://www.illinoislegalaid.org/index.cfm?fuseaction=home.dsp_content&contentID=327. (last visited Nov. 18, 2007).

[30] 735 ILL. COMP. STAT. § 5/15-1602. This right is only available once every five years. § 5/15-1602.

[31] ANDREA LEE NEGRONI, ET AL., RESIDENTIAL MORTGAGE LENDING: STATE

seven months after she receives notice, or three months after the date of entry of a judgment of foreclosure, whichever is later.[32] In order to redeem property, the mortgagee must pay all of the remaining principal due, plus costs and fees. There are additional protections for high-risk home loans, most importantly a one time per loan opportunity for a mortgagor to delay foreclosure for 30 days by seeking credit counseling.[33]

All foreclosures in New Jersey occur via judicial proceedings,[34] usually a public sale,[35] and typically take eight to twelve months.[36] New Jersey law requires that the mortgagee provide a notice of intention to foreclose thirty days prior to commencement of proceedings, or acceleration.[37] The mortgagor can reinstate their loan by paying the entire amount in default plus court costs and attorneys' fees. The mortgagor does not need to pay accelerated indebtedness to invoke the reinstatement right. The right to reinstate exists at any time up to the entry of final judgment, usually 10 days after the sale.[38]

Much has been written about mortgage default, medical debt, and families in financial distress, but there is surprisingly little borrower-reported data regarding medical crises as trigger events for mortgage foreclosure. Most theoretical discussion of mortgage default is founded on the theory that borrowers have the option of whether to make the mortgage payment, refinance the loan, or default on the loan

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REGULATION MANUAL NORTH CENTRAL, ILLINOIS MORTGAGE LENDING, § 2:19 (Aug. 2007), *available at* RML-SRNCN IL s 2:19 (Westlaw).

[32] 735 ILL. COMP. STAT. § 5/15-1603. If the mortgagee is the purchaser at the sale and the sale price was less than the amount previously required to redeem the property, the mortgagor can redeem for an additional 30-day period after the date the sale is confirmed by paying to the mortgagee the sale price plus all related costs, expenses, and interest. § 5/15-1603.

[33] Residential Mortgage License Act of 1987, ILL. ADMIN. CODE tit. 38, § 1050.1280 (2007); NEGRONI, ET AL., *supra* note 31 at § 2:19.

[34] Although other types of foreclosure may still be "theoretically possible," judicial foreclosures are the only type of foreclosure method used in practice. 5 BAXTER DUNAWAY, THE LAW OF DISTRESSED REAL ESTATE § 76:19 (14th release 2006).

[35] A mortgagee can initiate an optional procedural where the mortgage debt is deemed satisfied without sale when the residential property has been abandoned, has no equity, or where the lender takes a deed in lieu of foreclosure. N.J. STAT. ANN. § 2A:50-63 (2000). It is anticipated that the use of this procedure will not be widespread. 5 DUNAWAY, *supra* note 34, § 76:25.

[36] ANDREA LEE NEGRONI, ET AL., RESIDENTIAL MORTGAGE LENDING: STATE REGULATION MANUAL NORTH CENTRAL, ILLINOIS MORTGAGE LENDING, § 2:19 (Aug. 2007), *available at* RML-SRNCN IL s 2:19 (Westlaw).

[37] N.J. STAT. ANN. §§ 2A:50-56 (2007).

[38] A mortgagee can reinstate a particular loan only once every 18 months. § 2A:50-57.

and allow the lender to take the property.[39] Much of the academic debate has centered on whether the choice made by the borrower under the "option theory" is "ruthless" with only the value of the mortgage and the fair market value of the home considered,[40] or whether the choice includes other borrower-related issues such as loss in income or medical crisis.[41] Despite the significant economic literature on the subject, further empirical research is needed to study "trigger events, such as divorce and death" and whether "some defaults [are] driven by a sudden drop or loss of income caused by unemployment or job loss or by a sudden increase in expenses, such as medical or legal fees[.]"[42]

There is some empirical data on borrower-level crisis and mortgage default, and in recent years this data has shed some doubt on the "option theory" account. Quercia, McCarthy, and Stegman analyzed data from Farmers Home Administration borrowers and found that contemporaneous net equity had no effect on default rates whereas income to payment ratios and the existence of crisis events had a significant effect on default.[43] In another study, Quercia, Cowan, and Moreno analyzed data from 4,200 borrowers who received credit counseling in Minneapolis-Saint Paul between 1991 and 2003. The researchers found that while health problems were a cause of foreclo-

[39] For a comprehensive (though now dated) review of the traditional literature of mortgage default, see Roberto G. Quercia and Michael A. Stegman, *Residential Mortgage Default: A Review of the Literature*, 3 J. HOUSING RES. 341 (1992); *see also* Kerry D. Vandell, *How Ruthless is Mortgage Default? A Review and Synthesis of the Evidence*, 6 J. HOUSING RES. 245 (1995) (analyzing a variety of models and theories and determining that the "frictionless option-theoretic models" are the most useful); *see also* Stark, *supra* note 14, at 640 n.3 (describing law review literature that discusses preliminary empirical studies of foreclosures in various locations).

[40] *See* James B. Kau, Donald C. Keenan & Taewon Kim, *Default Probabilities for Mortgages*, 35 J. URB. ECON. 278, 278 (1994) (suggesting that transaction costs play little or no role in mortgage default decisions); *See also* Gordon W. Crawford & Eric Rosenblatt, *Efficient Mortgage Default Option Exercise: Evidence from Loss Severity*, 10 J. REAL EST. RES. 543 (1995).

[41] John M. Quigley & Robert Van Order, *Explicit Tests of Contingent Claims Models of Mortgage Default*, 11 J. REAL EST. FIN. AND ECON. 99, 100 (1995) (stating that if homeowners are rational, transactions costs, such as reputation costs, are needed to explain default behavior). *See also* Brent W. Ambrose & Charles A. Capone, *Modeling the Conditional Probability of Foreclosure in the Context of Single-Family Mortgage Default Resolutions*, 26 REAL EST. ECON. 391 (1996) (arguing that trigger events can lead to foreclosure even for borrowers with positive equity, who are unable to raise cash or to sell the property).

[42] Vandell, *supra* note 39, at 259.

[43] Roberto G. Quercia, George W. McCarthy & Michael A. Stegman, *Mortgage Default among Rural, Low- Income Borrowers*, 6 J. HOUSING RES. 349,363 (1995).

sures, those causes were in decline from 25% to 20%, while causes such as job loss or money management had increased.[44] In 2005, Collins conducted one of the few mailed surveys concerning mortgage foreclosure, surveying 299 predominantly minority, low income households in Chicago, and found that 33% of respondents listed medical problems as a cause for their foreclosure.[45] And in early 2007, Freddie Mac presented basic analysis on the chief causes of mortgage delinquency from the borrower's perspective, with loss of income the biggest cause, 36% in 2006, and illness ranking second, 21% in 2006.[46] The Freddie Mac study asks for, and reports, only the "chief" cause of mortgage delinquency for each respondent, and mortgage delinquency is a stage prior to initiation of foreclosure proceedings. Together, these studies suggest that medical crises may account for one quarter to one third of mortgage foreclosures, but none of them have explored the ways that various causes interact, nor explored other medical causes in depth, such as the amounts of un-reimbursed medical bills each respondent paid.

Beyond the context of mortgage foreclosures, medical debt has been studied and linked to a weakening of housing security.[47] Various studies by nonprofit advocacy organizations have shown that medical debt can lead to housing problems such as difficulty acquiring housing

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[44] Roberto G. Quercia, Spencer M. Cowan & Ana Moreno, *The Cost-Effectiveness of Community-Based Foreclosure Prevention* 21 (Joint Center for Housing Studies of Harvard University, Working Paper, Paper No. BABC 04-18, 2004), *available at* http://www.jchs.harvard.edu/publications/finance/babc/babc_04-18.pdf.

[45] J. Michael Collins, *Exploring the Design of Financial Counseling for Mortgage Borrowers in Default*, 28 J. FAM. & ECON. ISSUES 207, 208, 213 tbl.2 (2007). The study was focused on the effectiveness of mortgage counseling. *Id.* at 208. Clients with injuries and medical problems were less likely to use telephone counseling only and more likely to use both face-to-face and telephone counseling. *Id.* at 213 tbl.2.

[46] *See* Press Release, Freddie Mac, 2006 Drop in Delinquencies Show Shifting Reasons Behind Single Family Late Payments, Says Freddie Mac (Apr. 25, 2007), http://www.freddiemac.com/news/archives/servicing/2007/20070425_singlefamily.html.

[47] *See, e.g.*, ROBERT W. SEIFERT, HOME SICK: HOW MEDICAL DEBT UNDERMINES HOUSING SECURITY 1 (The Access Project 2005). *See also* MICHELLE M. DOTY, JENNIFER N. EDWARDS & ALYSSA L. HOLMGREN, SEEING RED: AMERICANS DRIVEN INTO DEBT BY MEDICAL BILLS 3 (The Commonwealth Fund, 2005), *available at* http://www.commonwealthfund.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf?section=4039 (analyzing the hardships faced by those unable to pay medical bills including taking out loans against their homes); Cathy Schoen, Michelle M. Doty, Sara R. Collins & Alyssa L. Holmgren, *Insured but Not Protected: How Many Adults are Underinsured?*, W5 HEALTH AFFAIRS 289, 296 (2005), http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.

due to poor credit and missing rent or mortgage payments.[48] In one study, one-quarter of families with at least one member lacking insurance reported having to "change their way of life significantly" to pay medical bills.[49] In 2005, Watson et al. studied 383 people in St. Louis, Missouri, finding that 53% of their respondents owed medical debt.[50] Of those with medical debt, 31% reported that the debt resulted in housing problems.[51] Pryor and Gurewich conducted a similar study in 2003 of 342 clients at two community health centers in Boston, Massachusetts.[52] They found that 41% of respondents reported having medical debt, with 53% of that group reporting that it caused housing problems.[53] Zeldin and Rukavina reported that in a phone survey of low to middle income households, those with medical expenses in the prior year had a higher average credit card debt than those who did not cite any medical expenses.[54] Although some of the studies note in passing that "[p]eople who owe medical bills often find themselves in court... sometimes leading to foreclosure,"[55] the relationship between mortgage foreclosure and medical distress remains underdeveloped.

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[48] SEIFERT, *supra* note 47, at 1; DOTY, *supra* note 47, at 3; Schoen, *supra* note 47, at 296.

[49] LISA DUCHON ET AL, SECURITY MATTERS: HOW INSTABILITY IN HEALTH INSURANCE PUTS U.S. WORKERS AT RISK 11, 16 chart17 (The Commonwealth Fund, 2001) *available at* http://www.commonwealthfund.org/usr_doc/duchon_securitymatters_512.pdf?section=4039. The figure rises to nearly 40% when none of the family members are insured. *Id.*

[50] SIDNEY D. WATSON, MARGARIDA JORGE, ANDREW COHEN & ROBERT W. SEIFERT, LIVING IN THE RED: MEDICAL DEBT AND HOUSING SECURITY IN MISSOURI 1, 22 (The Access Project, 2007), *available at* http://www.accessproject.org/adobe/living_in_the_red.pdf.

[51] This remained significant even with low amounts of debt, as 15% of the respondents with medical debt under $500 and 27% with debt between $500 and $1,000 reported housing problems. *Id.* at 1.

[52] CAROL PRYOR & DEBORAH GUREWICH, GETTING CARE BUT PAYING THE PRICE: HOW MEDICAL DEBT LEAVES MANY IN MASSACHUSETTS FACING TOUGH CHOICES 13 (The Access Project, February 2004), *available at* http://www.accessproject.org/downloads/MAreport.pdf.

[53] *Id.* at 6.

[54] CINDY ZELDIN & MARK RUKAVINA, BORROWING TO STAY HEALTHY: HOW CREDIT CARD DEBT IS RELATED TO MEDICAL EXPENSES 4-5 (2007), *available at* http://www.demos.org/pubs/healthy_web.pdf.

[55] Seifert, *supra* note 47, at 9 (citing GRACE ROLLINS, UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES (Connecticut Center for a New Economy, January 2003)); *See also*, Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1 (describing the effect of aggressive collection practices used by hospitals); *cf.* Lucette Lagnado, *Full Price: A Young Woman, an Appendectomy, and a $19,000 Debt*, WALL ST. J., Mar. 17, 2003, at A1 (depicting the economic troubles that resulted after a young woman

The Consumer Bankruptcy Project (CBP) provides a successful model for studying families in financial distress, drawing data from bankruptcy records, written surveys, and telephone interviews in 1981, 1991, 2001 and now 2007 forthcoming.[56] The CBP originally used only court records to link medical bills to bankruptcies.[57] However by 2001, it had become routine for debtors to pay medical bills with credit cards, which would be listed as general debt in court records and would not be traceable to a medical cause. Given this gap and other developments, the researchers also began using written and telephone surveys to acquire information from the debtors themselves, as we did in the present study.

Jacoby & Warren reported that 46% of debtors in the 2001 survey self-identified a medical cause for their bankruptcy, with 21% of debtors in the written survey reporting missing at least 2 weeks of work due to a medical injury and 26% reporting having medical bills in excess of $1000 that were not covered by insurance in the two years before filing for bankruptcy.[58] Jacoby & Warren posited that perhaps 63% of the debtors they surveyed had a medical-related bankruptcy.[59]

In a widely cited article also based on the 2001 dataset and supplemented by in-depth interviews with respondents who indicated medical causes of their bankruptcies, Himmelstein, Warren, Thorne and Woolhandler concluded that about 2 million Americans (includ-

underwent surgery without medical insurance).

[56] *See, e.g.*, TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA 168 (1989) (reporting CBP survey data); ELIZABETH WARREN & AMELIA WARREN TYAGI, THE TWO-INCOME TRAP: WHY MIDDLE-CLASS MOTHERS AND FATHERS ARE GOING BROKE 181-88 (2003); Robert M. Lawless & Elizabeth Warren, *The Myth of the Disappearing Business Bankruptcy*, 93 CAL. L. REV. 743, 769 (2005) (describing phases of data collection for the CBP). The project was initiated by Professors Teresa Sullivan, Jay Westbrook, and Elizabeth Warren in 1981 and 1991. By 2001, the team expanded to include Professors David Himmelstein, Robert Lawless, Katherine Porter, John Pottow, Deborah Thorne, Susan Wachter, Steffie Woolhandler, then-Professor and now-Judge Bruce Markell, and then-Professor and now-Dean Michael Schill. The CBP has conducted its most recent survey in 2007, and results are forthcoming. Many of the questions in our survey were based on the CBP's draft survey, and we are grateful to the entire team.

[57] *See* SULLIVAN ET AL., *supra* note 56.

[58] Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW U. L. REV. 535, 548-49, 551 (2006).

[59] *Id.* at 552 fig.3. Jacoby and Warren noted that not all researchers would agree with what they included under the realm of medical-related bankruptcy, and presented the data under alternative calculations, but concluded that "[b]y any analysis, this study finds a substantial number of families filing for bankruptcy in part to deal with the fallout from medical problems." *Id.*, at 551

ing filers and their dependents) suffered medical bankruptcies in a one year period.[60] Medical bankruptcies are not static; these authors estimated that the phenomenon had grown twenty-fold since the preliminary study in 1981.[61]

The present empirical study of mortgage foreclosure provides a useful supplement to the bankruptcy data, as an alternative measure of financial distress in America. In sheer numbers, in 2006, mortgage foreclosures affected a larger cross-section of America, striking at about double the rate of bankruptcies.[62] Federal bankruptcy is an "imperfect proxy for financial ruin"[63] because it is a voluntary proceeding initiated by the debtor himself or herself, who therefore must have the financial and personal wherewithal to take this rather drastic remedy.[64] Moreover, bankruptcy is only attractive to those who have nonexempt assets or income that they are seeking to protect from creditors, and who have the cash on hand to pay an attorney to prepare and submit the filing. The most destitute Americans face financial distress without bankruptcy protection.

In contrast, foreclosure proceedings are involuntary for the debtors, as they are initiated by lenders at their own discretion, and the holder of a security interest on a house can exercise it, regardless of whether the homeowner has exempt equity therein.[65] As the bankrupt-

[60] David U. Himmelstein et al., *Market Watch: Illness And Injury As Contributors To Bankruptcy*, W5 HEALTH AFFAIRS 63, 63 (2005), http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1. *Compare* Himmelstein et al. which used a narrower definition of medical bankruptcy, finding that 54.5% had medical causes, in contrast to the 63% in Jacoby and Warren *supra* note 58.

[61] Himmelstein et al., *supra* note 60, at 71.

[62] *Compare* Press Release, Administrative Office of the U.S. Courts, Bankruptcy Filings Plunge in Calendar Year 2006 (Apr. 16, 2007), *available at* http://www.uscourts.gov/Press_Releases/bankruptcyfilings041607.html (announcing that 617,660 bankruptcy cases where filed in 2006) *with* Press Release, RealtyTrac, *supra* note 1 (announcing 1.2 million foreclosure filings in 2006). Note, however, that 2006 was an odd year for both bankruptcies and foreclosures, with a dramatic decrease in bankruptcies following passage of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 and a dramatic increase in foreclosures. *See id.*

[63] Himmelstein et al., *supra* note 60, at 71.

[64] It is possible for creditors to file an involuntary petition for bankruptcy, however this is an extremely rare occurrence generally, and even more rare for consumers. David S. Kennedy, James E. Bailey, III, R. Spencer Clift, III, *The Involuntary Bankruptcy Process: A Study of the Relevant Statutory and Procedural Provisions and Related Matters*, 31 U. MEM. L. REV. 1, 3 (2000) (In 1998 "less than 1/1000 of one percent of all bankruptcy cases filed were commenced involuntarily." (citation omitted)).

[65] This voluntary versus involuntary distinction only focuses on the legal filing itself. Whether individuals are forced into financial distress by exogenous factors is a distinct, though more fundamental, question.

cy authors acknowledge, "many people financially ruined by illness are undoubtedly too ill, too destitute, or too demoralized to pursue formal bankruptcy."[66] These people, on the other hand, will show up in the foreclosure filings, although they may or may not respond to our surveys. Indeed, only one third of our respondents (34%) reported that they had ever in the past declared bankruptcy, and only 15% of the total respondents had either "tried," or were planning to declare bankruptcy as a solution to their impending foreclosure. By sampling a different population than other studies, our survey helps complete the picture of financial distress in America.[67]

On the other hand, our foreclosure study is in some ways more limited than the bankruptcy studies. Mortgage foreclosure is obviously limited to homeowners, while bankruptcies cover both homeowners and renters. Another significant weakness of our data compared to the ongoing bankruptcy studies is that we only have a snapshot in time of four states rather than a national sample repeated several times over a quarter century.[68] Thus, we are unable to control for geographic variations and measure longitudinal changes over time.

II. RESEARCH METHOD

We mailed surveys to 2,000 homeowners in four states: California, Florida, Illinois and New Jersey.[69] We chose these states primarily in an attempt to reach people in a broad range of geographic, lifecycle and socio-economic situations, though we were also constrained by data availability, and certain features of particular state foreclosure laws. Geographically, these states include both coasts, the north and the south, and the interior of America. As for life cycles, in America, 12.4% of the population is over 65 years of age, and two of our states, Florida and New Jersey, are above this average while two others, Cal-

[66] Himmelstein et al., *supra* note 60, at 71.

[67] *See* Richard M. Hynes, *Bankruptcy and State Collections: The Case Of The Missing Garnishments*, 91 CORNELL L. REV. 603, 606 (2006) (studying state law debt collection defendants and arguing that "[i]f we are to understand the extent of consumer financial distress, we must look beyond bankruptcy").

[68] The CBP has only this year undertaken a national sample. In previous years, it used a selection of individual judicial districts around the country. *See generally* sources cited at note 58 *supra*.

[69] We obtained funding and supplies sufficient to mail 2000 surveys, and we estimated that our response rate might be high enough to justify sending 500 surveys to any given state. So we selected four states to survey. Because we wanted a significant number of returns from each state, we did not weight them according to population in our mailings, but rather weighted the final results when making national comparisons.

ifornia and Illinois, are below.[70] Except for Florida, these states have higher median home values than the national median of $119,600, but these states, again except for Florida, also have higher median incomes than the national median of $44,434. So, while these states include a reasonable cross-section of America, future studies should aim to be more comprehensive, and scientifically representative.

We also selected these states out of sheer practicality. In some states, foreclosures proceed from notice to disposition too quickly and the filings are not publicly accessible quickly enough to survey the homeowners by mail.[71] As a result, we focused on states where the notices of foreclosure were readily accessible within days of the filings, but where the homeowners would still likely be in the homes for several weeks, during which they could receive and respond to our survey. There is a potential source of selection bias here – states with quicker foreclosure procedures could make foreclosure less expensive for lenders, and therefore cause them to turn more readily to this remedy. Thus, the potential survey populations in those states could have different characteristics than the ones we surveyed. This problem could be explored and remedied by future studies using telephone surveys instead of mail.

We obtained names, addresses, and basic property information for recent mortgage default notices from the Westlaw real property pre-foreclosure database for each state. The Westlaw databases contain information filed with the county clerk or recorder in select counties that relates to court filings for foreclosures or notices of default. Most of the information is usually provided by the party filing with the clerk—generally, the mortgage lender attempting to foreclose on the mortgage.

On November 27, 2006, we extracted all mortgage foreclosure records for single-family properties and residential condominiums that had been recorded within the previous 30 days from the appropriate pre-foreclosure databases.[72] Seeking only to survey homeowners, we

[70] U.S. Census Bureau, QuickFacts, http://quickfacts.census.gov/qfd/ (last visited Oct. 26, 2007) (use drop down box to view a particular state's census information).

[71] For example, we considered surveying homeowners in Texas, but foreclosures in Texas can be completed within 21 days of the initial court filing. Many of the counties submit their data only bi-weekly. To get enough foreclosure notices in Texas, we would have had to use records that had been filed in court almost a month before we queried the database. By the time our survey would have reached the mailing address, it is likely that many of the homeowners would already have been forced from their homes. As a result, we were unable to survey homeowners in Texas.

[72] To obtain enough records from New Jersey, we had to extract records for the previous 60 days. We obtained 6577 records from California, 1679 from Florida,

filtered out commercial and investment properties by keeping only records for which the defendant mailing address was the same as the property address.[73] We then randomly selected 500 records from each state to receive surveys.[74]

We designed our survey packet to maximize the response rate, and included a one dollar gift to encourage participation.[75] The survey instrument was designed to be easily readable,[76] and we circulated drafts for comment to bankruptcy attorneys who regularly work with these populations.[77] The survey was six pages, covering a variety of

761 from Illinois, and 900 from New Jersey. Because counties update their data on different schedules (a few update daily, many update weekly or biweekly, some update monthly, and a handful update only bi-monthly), the median record date varied by state and some counties were disproportionately represented in our initial data extraction. The median recording date for the California data was November 7, it was November 2 for Florida and Illinois, and it was October 19 for the New Jersey data.

[73] A small number of institutional defendants made it through this filter, but we identified them by visual inspection after the survey sample had been selected. After filtering, we had 4348 records from California, 856 from Florida, 540 from Illinois, and 739 from New Jersey.

[74] We sampled 500 from each state for simplicity, though it implies that some states were over-sampled and others were under-sampled. Our subsequent comparisons across states rely on appropriately weighted averages. See for example *infra* note 84.

[75] We printed cover letters on high-bond, color Harvard Law School letterhead, and all three authors signed each of the 2000 letters in blue ink. The letter mentioned our advisor, Professor Elizabeth Warren, by title and name, and mentioned that she had published well-known books and has appeared on the popular Dr. Phil television show. We hand-stamped both the outer and return envelopes with brightly-colored stamps, and we included a crisp, new one-dollar bill in each packet. We strongly emphasized the confidentiality of the responses. We also attempted to call every recipient who had not yet responded, encouraging them to complete the survey on the telephone. In short, we followed the techniques shown to increase survey response rates. See generally, DON DILLMAN, MAIL AND INTERNET SURVEYS: THE TAILORED DESIGN, SECOND EDITION (2007).

[76] For example, we presented respondents with 21 possible contributing causes and asked them to check all factors that contributed to their default, but we were worried that respondents would be less inclined to read the entire list and to check causes further down on the list. Therefore, we broke the question into five subquestions, each containing a list of four or five answer options. Unfortunately, we did not randomize or vary the order of the response options across individual surveys in order to test this potential source of bias. Nonetheless, the 'standard account' factors, as we are calling them, (i.e., "amount due for monthly mortgage payment increased", and "loan was not affordable from the beginning") were the first two options listed, while the medical factors, which we are exploring as an alternative hypothesis, were in slots six through nine. Thus, any such bias towards the top of the list, or towards either end of the list would make our findings more significant. The second-most popular response ("had to pay unexpected expenses ...", at 49% of respondents) was in slot fifteen, suggesting that if there is a bias in this regard, it is modest.

[77] We also placed a notice in Spanish at the top of the first page asking Span-

issues and collecting basic demographic data, and included a blank page at the end to allow respondents to explain their situation in greater detail.

We sent the surveys by first-class mail. We received 113 completed survey responses in the mail. An additional six surveys were returned by the recipients without responses, and 187 were returned by the post office marked "address unknown," perhaps because the residents failed to prevent foreclosure and were evicted, without leaving a forwarding address. To increase our overall response rate, we called all of the non-respondents for whom we could obtain phone numbers.[78] Fifteen people answered the survey over the phone, bringing our total response count to 128, for a response rate of 7% (128 responses of 1813 valid postal addresses).[79]

To check for bias in our relatively small number of responses, we obtained data from a website that compiles real-estate property data, Zillow.com, on most of the 2000 properties we had randomly selected to receive surveys.[80] According to the data from Zillow.com, our respondents had a mean/median home value of $324,581 / $250,063, whereas our non-respondents had a mean value of $349,065 / $283,726 — a difference of about $25,000, but not statistically significant even at as low as the 80% confidence level. There were also no significant differences between respondents and non-respondents at the state level.[81] We also found no statistically significant differences

ish speakers to check a box and return the survey even if they were unable to complete it. We received no such returns.

[78] The Westlaw pre-foreclosure database records do not contain phone numbers for defendants, so we obtained phone numbers in bulk from online white pages. We were able to obtain phone numbers for 349 of our non-respondents; we attempted to call them all at least once.

[79] We received 22% of our responses from California, 32% from Florida, 20% from Illinois, and 27% from New Jersey. Two-thirds (64%) of our respondents were white, 18% were African-American, 8% were Hispanic, and 7% were Asian-American. As discussed in Part III (A) *infra*, with reference to their incomes and home values, our respondents looked quite like the median persons in their states.

[80] We were able to extract estimates for home value and recent value appreciation for almost 90% of the addresses we selected, and we extracted square footage and year built for about 78% of the addresses outside of New Jersey. Aside from rough valuation estimates, Zillow.com did not have property characteristic data for New Jersey addresses. For addresses outside New Jersey, we were also able to obtain the number of bathrooms for 76% of the records and the number of bedrooms for 51% of the records.

[81] Obviously, our low response rate makes it harder to find significant differences. The mean value ($223,063) for our respondents in Florida was noticeably lower than the value ($299,578) for the Florida non-respondents, but due to the large variation in values, the difference was not statistically meaningful at as low as the 90% confidence level.

between respondents and non-respondents in terms of mean and median home purchase prices, the change in home value over the recent 30 day period, the square footage of the home, the year the home was built, the number of bedrooms, or the number of bathrooms.

With regard to potential response bias, one concern would be that those with medical or other exogenous causes would be more likely to respond, wanting to tell their stories, while those who had caused their own foreclosure by purchasing a home they could not afford or making a bad bet on the real estate market, would be too embarrassed to respond. The year in which people had purchased the homes now in default would provide some indication of whether this response bias is present. If there were such a response bias, one would expect to see non-respondents with significantly more recent home purchases, compared to the respondents who would have been able to afford their homes until encountering a medical or other crisis. The average date purchased for these two groups was within six months of each other, yielding no statistically significant difference on this score ($n = 1112, 71$, $p = .22$). Thus, if there is a response bias in this data, it is too subtle to be detectable with the data on hand. Nonetheless, even with these modest tests of bias, the relatively low response rate is a cause for concern, and readers should consider our findings conditional until a more robust study can further test our hypotheses.

III. FINDINGS

Our surveys included both subjective data, in which respondents themselves specify what they believed caused their foreclosures, and purportedly objective data -- the raw facts reported by the respondents about their situations, such as whether they currently have health insurance. As noted above, we also relied on data about the properties of both respondents and non-respondents. Together, these three sources of data complement each other and paint the picture of foreclosure.

The Standard Account

Our data shed light on what we have called, "the standard account" of the causes of home foreclosures.[82] This standard account focuses on lax lending standards, rising interest rates, and irresponsible borrowers who are walking away from upside-down mortgages on houses they simply cannot afford. Relevant to this explanation, we have data regarding the homeowners' self-reported causes of foreclo-

[82] See discussion surrounding and sources cited in notes 3-5 supra.

sure, their time in residence, their incomes and secured debt, and their home equity.

Of the respondents, only one third (36%) said that increasing mortgage payments were a factor in their default, and only one in six (16%) reported that their loan was actually unaffordable from the beginning. In contrast, three quarters of respondents (76%) reported that their foreclosure was caused by a drop in income (57%) or unexpected expenses (49%). As we see below, medical crises strike on both of these fronts.

As shown in Table 2, these homeowners reported surprisingly high household incomes, earning $52,000 annually on the median.[83] This puts them squarely in the middle-class, matching the $51,000 median household income for residents of their four states, weighted appropriately.[84] The respondents also owned fairly typical homes for their states, with a median value of $254,023.[85] In comparison, the

[83] The average income was even higher, at $58,567. Unfortunately, we did not ask respondents to distinguish between their incomes before and after their medical or other crises that caused the mortgage default. Thus, the reported figure could represent the income they were receiving before being injured, or it could represent their actual income now that they are unemployed. Assuming that some respondents may have answered the question one way, and some may have answered it the other way, one might assume that the average income, pre-medical crisis, is higher than the reported figure, even though the average actual income, during the medical crisis, is lower than the reported figure. Consistent with this hypothesis, we found a significant difference in the income levels of those who had a medical cause of foreclosure. Those without a medical cause had a mean/median income of $75,000 / $55,000, while those with a medical cause had $52,000 / $45,000. However, in regression models accounting for other factors, such as age, race, and state of residence, this difference became insignificant.

[84] U.S. Census Bureau, Two-Year-Average Median Household Income by State: 2003-2005, http://www.census.gov/hhes/www/income/income05/statemhi2.html (last visited Oct. 26, 2007). We took the 2004-2005 medians for each state, and then to estimate the 2006 value we used the same percentage change for each state in the previous period. We then weighted each state according to the number of responses we received in order to produce a weighted average of $50,988. On this score, the incomes for population of the four chosen states are quite similar to the projected 2006 U.S. median income of $47,913 (a difference of 6%). At $52,000, our respondents earn about 9% more than the national median. Note, however, that here we are comparing the *homeowners* in our sample, with all residents of their states, including those who do not own homes. The average income of those with mortgages nationwide in 2006 was $70,667. U.S. Census Bureau, Financial Characteristics for Housing Units with a Mortgage, http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=D&-gr_name=ACS_2006_EST_G00_S2506&-ds_name=D&-_lang=en (last visited Oct. 26, 2007) (note that the 2005 dataset for Table S2506 lists the median household income for homeowners with a mortgage in 2005 as $67,852).

[85] The average house was $324,213. This estimate is based on data from Zillow.com. We also asked respondents to estimate the current value of their homes,

median home values for residents of the four states, weighted appropriately, is $320,931.[86] Together, these observations suggest that although these respondents have typical incomes, their homes are actually less expensive than the median homes in their states.

Table 2: Comparison of Foreclosure Respondents to State Base Rates

	Foreclosure Respondents	Four-State Weighted Averages
Household Incomes	$52,000	$51,000
Home Values	$254,023	$320,931
Ratio	4.9	6.2

We estimated the respondents' required mortgage payments based on the total amount of secured debt and interest rate each reported, assuming a thirty-year amortization.[87] Based on this relatively crude

and they were largely consistent with the Zillow data, with a mean of $346,664 and a median of $259,000. A paired t-test reveals that the differences are insignificant ($p = .14$).

[86] This is based on state medians estimated by Zillow.com, drawn at the same time that the property-level data was drawn. The medians were: California, $524,716; Florida, $233,743; Illinois, $231,023; and New Jersey, $357,955. Zillow.com estimated that the United States median home value was $263,308. This is within 4% of our respondents' home value of $254,023, suggesting that on this measure at least, our respondents look quite like middle America. However, at $320,931, the housing stock in the four surveyed states is 26% higher than the national median, even though the incomes for residents of these states is only 6% higher. *See supra* note 84. Thus, residents of these sampled states can be expected to have somewhat more difficulty affording their homes, and therefore may find it more necessary to use exotic mortgages. *See supra* note 4 and accompanying text. A future national study of the causes of foreclosure might find an even larger percentage of medical causes relative to simple issues of unaffordability.

[87] The thirty-year amortization is the most typical loan type. *See* Federal Housing Finance Board, Terms on Conventional Home Mortgages: Table II – National Averages for All Major Lenders: Loans Closed, http://www.fhfb.gov/GetFile.aspx?FileID=6582 (last visited Sept. 29, 2007) (reporting average time to maturity for fixed rate loans being 29.0 years for fixed-rate loans and 30.1 years for variable rate loans, for those closing in December 2006). This estimate of monthly payments does not include insurance or taxes, and will be inaccurate for respondents who have a longer or shorter loan period, and also fails to account for respondents who are using interest-only loans or other variations on the standard loan model. Also, note that this benchmark is distinct from the "Total Fixed Payment to Effective Income" benchmark that is sometimes used in the alternative, and is therefore not a measure of total housing costs, which would include utilities

estimate, the median homeowners in our sample spends less than one third (32%) of their income on their estimated mortgage payments.[88] This puts our respondents, all of whom are in foreclosure, just above the Federal Housing Administration (FHA) benchmark of 29%.[89] Almost half (47%) of our respondents meet or beat the FHA benchmark. We estimate that the median respondent can completely meet his or her mortgage payments, and have $32,707 left over for other living expenses.[90] Nonetheless, given that these people are all in foreclosure, we suspect that many respondents reported their normal annual incomes, even though their mortgage foreclosures were precipitated by a sudden loss in income. If we had instead asked how much they earned in the most recent weeks or months, the annualized amount would likely have been somewhat lower. Future studies should attempt to clarify this point.

We also calculated the amounts of equity that respondents had in their homes –the home's market value minus the secured debt on the home.[91] As noted above, the traditional theory of mortgage default is that homeowners will exercise the "option" to walk away when their homes are worth less than they owe on them.[92] However, our median

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and maintenance. This is also distinct from the "Back End Ratio" which includes the burden of servicing all the consumer's debts, including both secured and unsecured. Rather, the present number is comparable to the FHA "Mortgage Payment Expense to Effective Income" benchmark *infra* note 89, and is merely a measure of mortgage payments to income.

[88] The mean is 52%, and is drawn up because some people reported extremely low incomes, likely due to a recent loss of income. For example, there were ten respondents that had ratios above 100% (with a maximum of 473%), meaning that they would have had to spend every penny of income on their mortgage payments, and they still could not have made them. Interestingly, 83% of these particular respondents indicated medical causes of their foreclosures, or indicia of medical crises, as defined below. Of those who had income-to-mortgage payment ratios above 50%, 91% cited medical causes or indicia of crises. *See* also note 83 *supra* (income data does not distinguish between income before or after medical or other crises.)

[89] HUD, 100 Questions & Answers About Buying a New Home, http://www.hud.gov/offices/hsg/sfh/buying/buyhm.cfm ("according to the FHA,[ ]monthly mortgage payments should be no more than 29% of gross income"), *see also* 7 C.F.R. § 1980.345 (2007) (allowing a 29% ratio for home loans under the Department of Agriculture programs); 38 C.F.R. § 36.4337 (2006) (allowing a 41% ratio for home loans under the Veterans Administration programs).

[90] The mean is $38,601. This figure is based on the estimate of mortgage payments explained *supra* note 87, deducted from the respondent's self-reported income.

[91] We used the respondents' self-reported amount of secured debt and compared it to both their own estimates of the home value and Zillow.com's estimate of the home values. There was no significant difference between these methods, so the self-reported data is discussed in the remainder of this paragraph. *See* note 85 *supra*.

[92] *See supra* note 39-42 and accompanying text.

respondent reports that he has about $50,000 in home equity, and the average respondent has $85,000 in equity.[93] Given that 85% of our respondents report having some equity in their homes, they do not appear to be walking away from upside-down mortgages, as the standard account would suggest.

Together, these observations paint a picture of foreclosure far different from that described by recent news articles. With decent incomes, moderate home values, reasonable debt burdens, and considerable home equity, these homeowners appear to be able to afford their homes, and have no reason to walk away from them. So why are they in default? It seems that either we have a severe response bias, revealing only the situations of an unrepresentative portion of those in foreclosure, or the standard account of home foreclosure is incorrect. As noted in our tests of response bias above, one prediction of the standard account would be that many of those in foreclosure had purchased their homes quite recently, but could not really afford them and therefore soon defaulted. However, the homeowners in our sample, and not just the respondents, have managed to pay their mortgages and avoid foreclosure for nine years on average, from the date that they purchased the home.[94] Thus, even with this small response rate, these preliminary findings compel further inquiry into the true causes of home foreclosure. What happened?

Self-Reported Medical Causes

In a major part of our study, we simply asked each respondent to mark each item on a long list that they believe "caused" them to get behind on their mortgage loans. We encouraged them to mark all that applied. The responses show that foreclosure can arise from a wide variety of causes including everything from natural disasters (5% of our respondents) to divorce (13% of our respondents). However, medical crises form a particularly striking pattern.

As shown in Table 3, about half of the respondents said that their foreclosure was caused at least in part by a medical problem. The total

[93] The exact figures are $85,561 mean and $49,900 median. When compared to the home value of $324,213 mean and $254,023 median, homeowners have 26% of home equity on average, and 20% on the median.

[94] The median is five years. This data is based on the respondents' reported dates when they purchased their homes. The mean is 1998 and the median is 2002. The surveys were completed in December 2006 and January 2007. We also collected the year the property was last sold from Zillow.com, but the data did not cover New Jersey and appeared to exclude properties that were bought long ago. When a paired T-Test is run to compare only those properties that have both estimates, the differences are insignificant ($p = .08$).

figure ranges from 49% to 57%, depending on which specific causes are counted as "medical" problems. These responses suggest that medical crises impinge on foreclosures in multiple ways. A third of the respondents and spouses (32%), were hit by an injury or illness. Medical crises are ultimately financial problems—causing a quarter (27%) to lose work, and a quarter (23%), to divert money towards paying medical bills instead of the mortgage. There is obviously significant overlap in these populations—for example, those with medical bills are also likely to lose work.

Table 3: Self-Reported Medical Causes of Foreclosure

	respondents	any of the above
Illness or injury of self or spouse	32%	
Others in family ill or injured	14%	
Loss of work due to illness or injury	27%	
Medical bills	23%	**49%**
Drugs or alcohol abuse	6%	
Gambling problems	2%	**50%**
Birth, or other family growth	9%	
Death in family	11%	**57%**

The abuse of drugs, alcohol, and gambling are all diagnosable psychiatric disorders, but we do not know how many respondents were actually diagnosed with these conditions. Whether or not these are included as medical causes is largely inconsequential, as their inclusion adds a marginal one percent. Change in family size, often due to birth, or death, typically includes medical aspects as well. Together, these add another 7%, raising the total proportion of respondents reporting medical causes of their foreclosures to 57%.

This is a striking finding, suggesting a far more significant connection between medical crises, and the potential loss of homes than scholars have previously observed. In contrast, recall that Michael Collins found that 33% of foreclosures are associated with medical causes and Freddie Mac found that 21% of delinquencies had illness as the primary cause.[95] It is not clear whether these differences are longitudinal, geographic, or methodological. Note that the Collins study was limited to one city, and had a shorter list of potential medical causes for respondents to choose from. The Freddie Mac differ-

[95] Collins, *supra* note 45, at 213 tbl.2; *See* Press Release, Freddie Mac, *supra* note 46.

ence may well be methodological, given that they only ask borrowers about the *primary* cause of their delinquency, rather than asking the borrowers to check *all* contributing causes, as we did. Moreover, the Freddie Mac data does not provide a list of the various ways in which medical causes can contribute to foreclosure, distinguishing medical bills from lost work for example, and therefore may elicit fewer accurate responses.

The fact that more than half of respondents identify some sort of medical cause has critical policy implications, suggesting that the cause of the foreclosure may be temporary and unpreventable, even though the results of foreclosure may be permanent dislocation. Nonetheless, it is also worth noting that most debtors cited one, two, or three other, completely distinct causes of foreclosure, including having trouble managing credit and exogenous shocks, such as natural disasters.[96]

With regard to objective indicia of medical crises, we found an even stronger relationship with mortgage default, compared to these subjective responses. Medical crises have the potential to impact either the income side of a homeowner's budget, or the expense side, or both.

Income Effects of Medical Crises

One very significant problem was the loss of work due to injury or illness. Three in ten (30%) of our respondents indicated that they, or their spouses, had missed at least two weeks of work due to illness or injury in the two years preceding their mortgage default. At the time of the survey, one in twelve (8%) were currently unable to work, due to medical reasons.

In their narratives, respondents explained the link between health and income. One wrote that, "I went off work due to medical reasons, so the money was just not there." Another explained that, "[I] was on top [of the payments] then had emergency surgery [and] was laid up for four months and couldn't go to work. Got behind." Likewise, a third respondent said that, "I fell behind because my husband was injured in a car accident[,] and went out on disability."

From a policy perspective, this connection between health crises and lost work suggests more attention must be paid to disability insur-

[96] The modal respondent cited five specific causes of their foreclosure (mean = 4.7, median = 5). We also categorized the 21 potential causes into three categories – medical causes, problems with credit, and exogenous causes. (The survey instrument does not make this distinction.) The modal respondent indicated at least one cause in all three categories (mean = 2.1, median =2).

ance, or other ways of bridging these sorts of temporary gaps, in addition to the typical policy focus on insurance for medical bills. Federal disability insurance, under the Social Security program, may not be large enough, or arrive fast enough to keep people in their homes.

Even if the homeowners are perfectly healthy, the illnesses of *other* family members can affect the income side of the ledger. One respondent explains, "I had taken time off from work when my mother was ill." Another describes her need to care for two women in her home. "[I] have to take care of mom, 88, and my aunt. Mom is dying, calls 911. I am forced to take care of her."

The survey evidence bears out these anecdotes. Three quarters of the respondents who had seniors in their homes reported medical causes for their foreclosures, while only 46% of those without seniors did so ($p < .05$). When limited to just medical problems afflicting "other family members" besides the respondent and spouse, four-in-ten (42%) of those with seniors cited this cause, while only one-in-ten (9%) of the others did so. In a logistic regression model[97] controlling for the age, sex, state, race, and income of the respondent, those with seniors in the house are significantly (thirteen times) more likely to report a medical cause related to "other family members."[98] From a

[97] A logistic model is a statistical regression model used to estimate the influence of exogenous explanatory factors on *whether a particular event occurs*. Here, we used age, sex, race, state and income of the respondent and whether there were seniors in the household as explanatory variables, and estimated their individual and collective influence on the likelihood that the respondent would report a medical cause. The general approach for logistic regression involves finding a *logistic* function that "best fits" the observed data, which include, for each observation, whether the event occurred (given a value of 1 if it occurred, and 0 otherwise) and the values for all of the explanatory factors. The logarithm of the odds of the event occurring is assumed to be a linear function of the explanatory variables, and the coefficients on the explanatory variables are determined essentially by maximizing the product of the probabilities the model assigns to the observed outcomes. The logistic is an increasing function that takes on values strictly between 0 and 1: $f(\theta) = e^{\theta}/(1+e^{\theta})$. In the logit model, used here, the single input value θ of the logistic function is itself a linear function of the explanatory values x_1, x_2, ...: $\theta = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \cdots$. Estimates of the coefficients β_i of the explanatory variables are found by choosing coefficients to maximize the product of $f(\theta)$ for observations where the event occurred and $[1-f(\theta)]$ for observations where the event did not occur. Values of the logistic function are commonly interpreted as probabilities that the event will occur conditional on the input values of the explanatory variables. For information on logit models and logistic regression generally, see G. S. MADDALA, LIMITED-DEPENDENT AND QUALITATIVE VARIABLES IN ECONOMETRICS 22-27 (Econometric Society Monographs No. 3, 1983).

[98] The model as a whole had significant predictive power at .05, and the seniors-in-household variable was itself significant which means roughly that there

policy perspective, this finding suggests that the national Medicare safety net may have a gap. Although Medicare pays for health care and some prescription drugs, seniors who need daily care may be forced to impose on relatives who must then stay home from work to care for them. A national policy failure for senior citizens also has implications for their adult children who must pick up the slack.

The Expenses of Medical Crises

One quarter of the respondents (23%) said that medical bills were a cause of the foreclosure. Still, the relationship is not direct: none of the respondents indicated that a medical creditor was actually foreclosing on their houses after reducing the debt to a judicial lien.[99] This sort of aggressive collections practice has been the subject of recent controversy, and has lead to some legislative responses.[100]

Instead, the interaction between medical expenses and foreclosure is more indirect, and the policy responses must therefore be more nuanced. Medical crises apparently cause homeowners to re-allocate some of the money they do earn away from the mortgage and towards medical expenses. One respondent explained that, "[i]nsurance pays less each year. [Our] prescription medications run over $200 per month for [the] family." The medical crises of others in the family can be costly as well. As one respondent explained, "[m]y mother took sick[,] and that put me behind for medical and funeral expenses."

Consistent with these narratives, over one third of the respondents (37%) reported that they had paid more than $2,000 in un-reimbursed medical bills in the two years before their mortgage default. At a $1,000 threshold, this figure climbs to 42% of the respondents, which is somewhat higher than that observed in the studies of medical bankruptcies.[101] Specifically, the mean/median respondent had $4,901 /

would be less than a 5% chance of observing the divergence in responses we actually observed if the presence of seniors in the household had no actual influence on whether a medical reason were reported.

[99] Rather, 97% of the respondents indicated the foreclosing party was either the primary mortgage lender or another mortgage lender. The remainder said it was some other special situation, such as the house being secured by a business loan which was defaulted.

[100] *See* Jacoby & Warren, *supra* note 58, at 576 n.218 (citing cases where judgment liens were filed by healthcare providers), 540-541 n.33-41 (showing the legislative responses, for example, Connecticut's provision that expands the homestead exemption when debts arise out of hospital services).

[101] Compare this with the 27% rate found by Himmelstein et al., *supra* note 60. This may be due to the differences in the populations of those in bankruptcy versus those in foreclosure, and it likely reflects a difference in time, between our late-2006 data and their 2001 data. Medical inflation alone would make $1,000 in

$1,250 of such un-reimbursed medical bills. For those who cited one of the four core medical causes for their bankruptcy, their un-reimbursed medical bills were $8,334 / $3,000, more than quintuple those who did not. Those that said medical *bills* were the *specific* cause of the foreclosure, faced $15,044 / $5,200 in bills. When one considers this smallest sub-group's income during this two-year period, these medical expenses would consume $17% of the mean income and 7% on the median. Of course, it is unlikely that the medical bills were conveniently spread across each paycheck.

These homeowners in foreclosure apparently reallocated their income towards paying medical bills rather than the mortgage, and this is cause for policy concern. From the perspective of rational choice economics, we might assume that with a fixed amount of money to allocate in any given month, and bills exceeding this amount, homeowners will select which bills to pay according to whichever creditor threatens the most negative consequences for nonpayment. It is generally more prudent to pay one's secured debts before the unsecured debts, and consumers are routinely advised as such.[102] Homeowners must know that the threat of losing their home is a severe potential consequence of default. Thus, when they allocate money elsewhere, it may reflect a lack of understanding about the relative seriousness of the consequences across these choices.

Or, the decision to pay medical bills over the mortgage might be quite rational and intelligent. Perhaps the medical creditors have even more practical leverage than the mortgage creditor who has a security interest in the home. Medical providers can simply refuse further treatment until the account is paid in full. Indeed, some medical providers may refuse to work on credit at all, requiring payment in full before rendering medical services, as explicitly contemplated by the Code of Medical Ethics.[103] Federal law requires that medical providers screen, and if necessary *stabilize* patients presenting with *emer-*

2001 medical expenses equivalent to about $1,300 in medical expenses at the end of 2006. *See* Bureau of Labor Statistics, U.S. Dep't of Labor, Medical Care Inflation in 2006, http://stats.bls.gov/opub/ted/2007/jul/wk5/art05.htm (last visited Nov. 3, 2007) (deducing from percentage increases in consumer price index related to medical care as noted in accompanying chart).

[102] *See, e.g.*, N.Y. City Dep't of Consumer Affairs, *Debt Collection Guide*, www.nyc.gov/html/dca/downloads/pdf/debt.pdf at 3 ("Pay your SECURED DEBTS first...").

[103] *See* AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS, E-608, *available at* http://www.ama-assn.org/ama/pub/category/8371.html ("Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment . . . .")

gency conditions, without regard to the patient's ability to pay.[104] However, when it comes to getting real treatment for an underlying ailment, there is no generally applicable legal limit to the use of leverage. Such a consumer is faced with a choice between their health or their home.

For one in twelve respondents (8%), the medical bills became so onerous that they resorted to refinancing their homes, or taking a home equity loan to pay their medical bills, often along with other debt such as credit card bills.[105] Indeed, of those respondents who took out home equity for any purpose, almost one quarter (23%) used it to pay medical bills.[106] This medical debt, now secured by their house, provides one reason why the median respondents owed over $50,000 more on their houses than the original purchase price.[107]

This conversion of unsecured medical debt to secured home debt presents another serious policy implication. Scholars have noted that the bankruptcy system exists as a last-resort social insurance system for people hit with medical catastrophes, allowing them to discharge their medical debts and get a fresh start.[108] One in five (19%) of our respondents with medical foreclosures indicated that they had declared, or were considering, bankruptcy. Nonetheless, for those who have secured their medical debts with their homes, bankruptcy is likely to be much less helpful. Bankruptcy treats secured debt much differently than it treats unsecured debt, such as amounts owed directly to

[104] Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd (2000 & Supp. IV 2007).

[105] On average, respondents tended to use home equity for 1.8 purposes, including medical bills (23%), mortgage payments (25%), living expenses (28%), other purposes not listed (29%), repairs and renovations (31%), and credit card bills (65%).

[106] Compare this to the 15% rate found by Himmelstein et al., *supra* note 60, at 68.

[107] The mean/median purchase price was $217,000/$137,000 while the mean/median amount of secured debt was $261,000/$189,000. The difference in means is $44,000; the difference in medians is $52,000. By the way, the respondent's disclosed purchase price tracked very closely to the property data gathered from Zillow.com, where the mean/median last sold price was $220,000/$145,000.

[108] *See generally*, Adam Feibelman, *Defining The Social Insurance Function Of Consumer Bankruptcy*, 13 AM. BANKR. INST. L. REV. 129, 129 (2005) (Collecting sources and concluding that, "Bankruptcy scholars generally agree that consumer bankruptcy functions, at least in part, as a form of social insurance. . . . To [some scholars], bankruptcy is effectively an 'insurer of last resort,' providing some measure of protection to individuals who fall through cracks in other private and public institutions and legal regimes designed to promote economic security.") *But see* Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 462-63 (2004) (arguing that the bankruptcy system has limited effectiveness as a system of medical insurance, in part because it provides no prospective relief and limits repeated use).

hospitals, doctors, or credit cards. In bankruptcy, these unsecured debts can sometimes be discharged totally, or often times at least partially, depending on the debtor's assets and income. In contrast, debtors must repay every penny of secured debts, up to the liquidated value of the collateral, and Chapter 13 bankruptcy instead merely allows the debtor to re-schedule those payments.[109] But for debts secured by a *home* in particular, bankruptcy is even less forgiving, requiring full payment according to the original mortgage contract, in addition to any payments on the arrears through the plan.[110] If you cannot pay these secured medical bills, then you lose your house.[111] Given that medical crises may be highly correlated with loss of income, the chances of being able to complete such a Chapter 13 plan may be doubtful.[112]

At the very least, we might expect bankruptcy's automatic stay to provide these debtors with a reprieve while they try to get their affairs in order.[113] But when medical debt is secured by a home mortgage that

[109] *See* 11 U.S.C.S. § 727(b) (limiting the discharge to liability on claims, not creditors' in rem rights in collateral); § 1325(a)(5)(B) (LexisNexis Supp. 2007) (requiring for approval of a Chapter 13 plan that "the value, as of the effective date of the plan, of property to be distributed under the plan on account of such claim is not less than the allowed amount of such claim; and [if the plan includes periodic payments] the amount of such payments shall not be less than an amount sufficient to provide to the holder of such claim adequate protection during the period of the plan").

[110] *See* 11 U.S.C. § 1322(b)(2) (2000) (specifying that a Chapter 13 plan may not modify the rights of holders of claims "secured only by a security interest in the real property that is the debtor's principal residence"); *see also* § 1328(a)(1) (withholding discharge from debts that have repayment schedules extending beyond the length of the plan); *see also* Administrative Office of the U.S. Courts, Chapter 13, at http://www.uscourts.gov/bankruptcycourts/bankruptcybasics/chapter13.html ("Debts not discharged in chapter 13 include certain long term obligations (such as a home mortgage) . . . .").

[111] 11 U.S.C. § 524(j) (The bankruptcy discharge "does not operate as an injunction against an act by a creditor that is the holder of a secured claim, if . . . such creditor retains a security interest in real property that is the principal residence of the debtor . . . ."),; *See also* Jacoby, *supra* note 108, at 464 ("Because that debt is secured, and particularly because it is secured by the debtor's principal residence, the debtor must pay that debt in full or she will lose her home.").

[112] See Scott F. Norberg & Andrew J. Velkey, *Debtor Discharge and Creditor Repayment in Chapter 13*, 39 CREIGHTON L. REV. 473, 505-06 tbls. 18 & 19, (2006) (reporting on longitudinal study of debtors who filed chapter 13 in 1994) (finding that two thirds of those entering Chapter 13 bankruptcies did not complete their plans).

[113] S. Rep. No. 95-989 (1979) *reprinted in* 11 U.S.C. §362 (2000) ("The automatic stay is one of the fundamental debtor protections provided by the bankruptcy laws. It gives the debtor a breathing spell from his creditors. It stops all collection efforts, all harassment, and all foreclosure actions. It permits the debtor to attempt a

exhausts the debtor's equity, the reprieve may be quite temporary. Because of the lack of equity means that the creditor also lacks "adequate protection" against a decline in value of the collateral, the mortgage holder can immediately move the court to lift the stay and thereby proceed with foreclosure.[114]

Still, for those debtors who have some equity in their homes, and have sufficient income to make a Chapter 13 plan work, bankruptcy can still be an effective solution to an impending foreclosure.[115] Over the course of a Chapter 13 plan, the debtor can gradually repay his mortgage arrearages while also paying regular payments under the mortgage contract. Thus, for those debtors who have temporary medical crises that do not dramatically impact their long term financial situation, by either reducing income or diverting it to medical expenses, Chapter 13 could be a way to protect their homes.

Given this legal regime, our preliminary data suggest that the bankruptcy system may not be a very effective safety net, even as a last resort, for those with medical crises. Given the prevalence of medical debt secured by homes, the bankruptcy safety net has very large holes that debtors can fall right through. Bankruptcy is no replacement for a comprehensive and prudent policy for financing health care in America.

Medical Insurance

Medical insurance exists to protect consumers from financial shocks caused by health crises. However, amongst the homeowners that we studied, a third of them (30% for respondents, 34% for spouses), had no health insurance whatsoever.[116] In contrast, for the weighted population of the four states we studied, only 17% lack insurance.[117] This significant difference ($p < .02$), suggests a strong relationship between the lack of health insurance and mortgage default.

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repayment or reorganization plan, or simply to be relieved of the financial pressures that drove him into bankruptcy.")

[114] 11 U.S.C. §362(d) (2000). ("[T]he court shall grant relief from the stay . . . by terminating, annulling, modifying, or conditioning such stay - (1) for cause, including the lack of adequate protection of an interest in property of such party in interest; (2) with respect to a stay of an act against property under subsection (a) of this section, if - (A) the debtor does not have an equity in such property; and (B) such property is not necessary to an effective reorganization.").

[115] *See* Melissa B. Jacoby, *Bankruptcy Reform and Homeownership Risk*, 2007 U. ILL. L. REV. 323, 327-28 (2007).

[116] For 37% of the households, either the respondent or his/her spouse lacked health insurance.

[117] The national average is 15%. U.S. Census Bureau, Current Population Survey 2005 and 2006 Annual Social and Economic (ASEC) Supplement.

Nonetheless, it is not clear that even those who do have health insurance receive adequate protection from it. For those households where both the respondent and the spouse *do* have insurance, the mean/median amount of un-reimbursed, out-of-pocket medical bills was $5,100/$2,000, while households with one or more uninsured paid only $4,565/$500 ($p > .1$). Contrary to what one might expect, those in foreclosure with health insurance pay about the same in un-reimbursed medical bills as those without health insurance.[118] Likewise, at about the same rate, both those with and without health insurance say medical problems, their own, or their spouse's, caused their foreclosure (33.8% and 30.4%, respectively).

Given that all of our respondents are in foreclosure, this is far from an ideal study design for considering whether medical insurance helps people in medical crises keep their houses. One explanation for these observations is that insurance effectively helps those with low and moderate medical bills avoid foreclosure, and thus the only insured people we see in our sample are those with very high medical bills who have surpassed their policy limits, or accumulated significant co-pays. Another explanation for this data may be adverse selection, such that those with medical problems and higher total bills may be more likely to be insured than others. Those who are over 65, or have very low incomes are thereby eligible for Medicare and Medicaid, which offset most medical expenses.[119]

CONCLUSIONS AND RECOMMENDATIONS

We define "significant medical distress" as occurring in those cases where a respondent self-identified a medical cause for their foreclosure, paid more than $2,000 in un-reimbursed medical bills, lost two or more weeks of work for illness or injury, are currently unable

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http://www.census.gov/hhes/www/hlthins/usernote/usernote3-21rev.html (last visited Oct. 26, 2007).

[118] This is consistent with the findings of those in bankruptcy. *See* Jacoby & Warren, *supra* note 58, at 553 (noting that two thirds of "medical filers" of bankruptcy said all family members had insurance, and 82.7 percent of those ill or injured had insurance at time of the interview, yet "those with private insurance at illness onset reported higher out-of-pocket costs on average ($ 13,460) than those uninsured at illness onset ($ 10,893)").

[119] *See* Robert Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 51 ST. LOUIS U. L.J. 325, 336 (2007) ("Non-elderly people were much more likely to face the burdens of medical debt than people age 65 and above (47% versus 29%). Possible explanations for this are 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.")

to work for a medical reason, or used home equity to pay medical bills. As shown in Table 4, we find that seven in ten homeowners (69%) experienced at least some indicia of a significant medical distress in the two years preceding their foreclosures.

Table 4: Seven in Ten Homeowners in Foreclosure Had Significant Medical Distress

	respondents	any of the above
Self-reported medical cause	50%	
Un-reimbursed med bills > $2000	37%	
Lost 2+ wks, work illness /injury	30%	
Currently unable to work, medical	8%	
Used home equity to pay medical bills	13%	
		69%

At the very least, this aggregate finding suggests that the standard account of home foreclosure may be missing a very large portion of the story. Those facing home foreclosure are often suffering from illness and injury. Even when these factors do not directly cause the foreclosure, they become part of the perfect storm of factors that push people over the brink.

It is worth pausing to consider how these findings about medical foreclosure relate to the standard account of the recent spike in home foreclosures. Undoubtedly, there has been a recent increase in exotic mortgages, predatory lending, and interest rates, while home prices remain flat.[120] Thus, some or perhaps all of the *increase* in foreclosures can be explained by the standard account. The question is thus, putting aside these temporary trends, what are the causes of the *base* rate of foreclosures? Our study provides only a snapshot in time, and does not provide such a base-rate with which we can estimate the prevalence of medical foreclosures as a proportion of all foreclosures. However, to the extent that these other factors were causing additional foreclosures during our study period of December 2006 and January 2007, we should expect the base rate to reflect an even higher percentage of foreclosures with medical causes. Of course, both the medical causes and the "standard account" causes are subject to policy interventions, which may in the future change (and hopefully decrease) the rate of foreclosures.

[120] *See Alternative Mortgage Products*, *supra* note 2, at 7-10.

The "standard account" causes of foreclosure are not completely independent of medical foreclosures. In many cases, various factors combine to push borrowers over the edge, into financial ruin.[121] Thus, in raw numbers, the spike in foreclosures due to these other causes might also cause a spike in medical foreclosures. Finally, given the observed relationship between medical crises and foreclosures, it is possible that changes in the health care economy during these same few years may have contributed to the spike in foreclosures.[122]

Before turning to questions of policy, it is worth emphasizing that our findings are the result of a *preliminary* study of the medical causes of home foreclosure, one that suffers from a relatively low response rate. Notwithstanding our checks of response bias, it is possible that the experiences of our respondents are not representative of the whole. So, as we begin to contemplate the meaning of these findings for law and policy, we do so conditionally, on the assumption that these findings can and will be replicated in more comprehensive future studies. The question is, *if* these observations are accurate, what do they mean?

Our most striking observations begin with the realization that most of those suffering medical foreclosures are solidly in the middle class, with apparently affordable homes, and health insurance to boot. Thus, none of the handy bromides are apt. Simply tightening mortgage lending standards, or providing health insurance to more Americans, is unlikely to solve the problem of medical foreclosures. Instead, this study contributes to a growing awareness that the middle class in America is financially insecure, both because they are living too close to the margins, and because they are now exposed to risks that can push them over the edge.[123] For example, recall that those who cited

[121] *See* note 96 *supra*.

[122] *See, e.g., Hearing on Economic Challenges Facing Middle Class Families Before the H. Comm. on Ways and Means*, 110th Cong. (Jan. 31, 2007) (statement of Diane Rowland, Executive Vice President of Kaiser Family Foundation, *available at* http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5415 ("From 2000 - 2006, the cumulative increase in premiums for employer-sponsored insurance was 87 percent compared to a 20 percent increase in wages and 18 percent increase in overall inflation . . . . Since 2000, the cumulative increase in premiums is over 4 times the increase in wages for non-supervisory employees. . . . Between 2001 and 2005, the share of middle-income employees in firms with employer-based coverage dropped from 82.4 percent to 78.5 percent and, in turn, their uninsured rate grew from 13.4 percent to 16 percent").

[123] *See generally* WARREN & TYAGI, *supra* note 56 (arguing that American families have almost all of their income locked up in necessities and have little in reserve for crises); JACOB HACKER, THE GREAT RISK SHIFT: THE ASSAULT ON AMERICAN JOBS, FAMILIES, HEALTH CARE, AND RETIREMENT AND HOW YOU CAN FIGHT BACK (2006) (arguing that the traditional pillars of financial security, the fami-

medical bills as the cause of their foreclosure were hit, on average, with over $15,000 in uncovered expenses. This sort of "exogenous shock" to their personal budgets was apparently too much for them to handle, and it pushed them into foreclosure. In this light, medical foreclosures are symptoms of larger policy problems.

Given the complexity of the problem of middle class financial insecurity, there is no simple solution. Enhancing real wages, minimizing the middle class tax burden, encouraging savings, and creating various governmental safety nets are all salient responses, but beyond the scope of the present study.

Nonetheless, there are specifically legal responses available to policy makers to address the narrower problem of medical foreclosures themselves. For one thing, this study suggests that the public discussion of universal health insurance needs to be sensitive to not just the problem of un-insurance, but also under-insurance. To be effective, health insurance must be done right – a policy with low caps or slow reimbursements may not keep people in their homes. Moreover, this suggests that in addition to insurance for medical bills, more attention needs to be paid to medical disability insurance, and home care insurance. Our respondents indicate that medical crises affect both the income and expenses side of a consumer's ledger, yet much of the contemporary discussions about healthcare reform focuses only on the latter.

Putting health policy aside, the problem of medical foreclosures could instead be addressed by housing policy and the mortgage industry. One potential response is to create a public or private insurance system to prevent the problem. Such insurance could pay the mortgage during a verifiable medical crisis in the borrowers' household, allowing those with only a temporary problem to overcome it without losing their homes in the process. For those with permanent medical problems, the insurance could provide a more orderly process of divesting themselves of the asset, while preserving whatever equity they have.[124] Alternatively, for those with permanent disabilities, the debt could simply be forgiven, as is done for federal student loans.[125]

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ly and the workplace, no long provide as much economic stability).

[124] *See* Stark, *supra* note 14, at 678-80 (proposing a birfurcated process, whereby those with significant equity in their properties would be allowed to sell the property "in a manner which is commercially reasonable and designed to produce a selling price close to the fair market value of the property").

[125] *See* U.S. Department of Education, *Repaying Your Student Loans*, at 23 n.1 available at http://studentaid.ed.gov/students/attachments/siteresources/RepayingYourStudentLoansEnglish2003_04.pdf ("Beginning July 1, 2002, a borrower who is determined to be totally and permanent-

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Preventing medical foreclosure is a positive sum game for the lenders, the homeowners, and the public.[126] Therefore, we could expect these three interests to be willing to invest together to purchase such insurance. If rational borrowers were told *ex ante* that half of all foreclosures are caused by medical crises, then, in theory, they should be willing to pay some amount for insurance to protect themselves from a medical foreclosure. Lenders, in return, should be willing to offer lower origination fees and/or interest rates, reflecting the reduced risk of default for the loans of such insured borrowers, which would thereby partially offset the cost of the insurance.[127] Finally, given the negative externalities of foreclosures, the government would have an interest in subsidizing this insurance, at least by making it tax-deductible.[128] Although attractive in principle, any such voluntary insurance program will be severely hampered by problems of bounded rationality.[129] Given the pernicious effects of optimism bias, homebuyers are unlikely to purchase such insurance, even if given the option to do so.

It should be noted that loan servicers already seek to modify mortgages, or grant forbearances when borrowers face a short-term financial crunch, so as to avoid the costs and risks associated with proceeding to a foreclosure sale.[130] Indeed, many of our respondents

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ly disabled will have his or her loan placed in a conditional discharge period for three years from the date the borrower became totally and permanently disabled. During this conditional period, the borrower doesn't have to pay principal or interest. If the borrower continues to meet the total-and-permanent disability requirements during, and at the end of, the three-year conditional period, the borrower's obligation to repay the loan is canceled.")

[126] *See supra* notes 8-11 and accompanying text.

[127] *See* Stark, *supra* note 14, at 641 (suggesting that without added security, "[l]enders will pass along the costs associated with delinquent mortgages to new borrowers in the form of higher loan fees or higher interest rates.").

[128] Alternatively, the government could provide a form of mortgage insurance directly to borrowers instead of, or as a supplement to, privately purchased mortgage insurance. The United Kingdom has such a two-policy system, but the complexity has hindered its effectiveness. *See* Janet Ford & Deborah Quilgars, *Failing Home Owners? The Effectiveness of Public and Private Safety-nets*, 16 HOUSING STUD. 147, 160-61 (2001) (explaining that the two-policy system fails to provide housing security as hoped, especially for the poorest homeowners).

[129] Amongst other problems, homeowners are likely to suffer from optimism bias, as they will tend to assume the medical foreclosures will happen to others, not themselves. *See*, Christine Jolls, *Behavioral Economics Analysis of Redistributive Legal Rules*, 51 VAND. L. REV. 1653, 1660-61 (1998) (describing empirical findings that individuals tend to under-estimate the likelihood of suffering an automobile accident).

[130] *See*, Amy Crew Cutts and Richard K Green, *Innovative Servicing Technology: Smart Enough to Keep People in Their Houses?* in BUILDING ASSETS,

likely worked out some such arrangement to stay in their homes.[131] However, such an offer may come only after the lender has initiated foreclosure proceedings, which incurs thousands of dollars of legal fees that are passed on to the borrower even if he or she ultimately cures the default.[132] Thus, homeowners should be advised to begin negotiating with their lenders much sooner, before foreclosure proceedings are initiated. Still, such negotiations will be of limited value to the homeowner who has no real choice about whether to default, since a servicer is free to proceed with foreclosure whenever it is economically rational to do so, without regard for the borrower's reasons for delinquency. Without some sort of legal entitlement to protect him, the borrower has little or no negotiation power.[133] Policymakers should explore ways to further incentivize mortgage servicers to deal with those suffering from short-term trigger events, so that these borrowers can avoid losing their homes, and avoid the onerous costs involved in such an involuntary transaction. In crude terms, if laws make it more expensive for lenders to consummate foreclosure, for example, by requiring that they use a judicial remedy, lenders will be compelled to instead negotiate with the marginal borrowers, some of whom will be able to re-instate their mortgages after a temporary set-

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BUILDING CREDIT: CREATING WEALTH IN LOW-INCOME COMMUNITIES 348, (Nicolas P. Retsinas & Eric S. Belsky, eds., 2005), *available at* http://www.freddiemac.com/news/pdf/fmwp_0403_servicing.pdf.

[131] *See* Stark, *supra* note 14, at 663 ("[O]nly a third or fewer of the foreclosure cases filed ended in a foreclosure sale."). A future study should explore whether there is a significant difference in the outcomes for homeowners depending on the reasons that caused their foreclosures in the first place. One might hypothesize that those entering default because interest rates have adjusted upwards might be more likely to actually lose their homes, while those suffering a temporary medical crisis may be more likely to negotiate a deal that saves their homes.

[132] See e.g, Brown v. Lynn 385 F. Supp. 986, 993 (N.D. Ill., 1974) ("[T]he mortgagees' collection attorneys are apparently charging high fees for what appears to be the mailing of a collection notice threatening foreclosure. Unless the mortgagor pays all existing deficiencies as well as these attorney's fees, the mortgagees institute foreclosure proceedings which apparently give rise to even greater costs and attorney's fees. Since, under [state law], the only defense to a foreclosure is the tender of the entire arrearage, plus all costs, fees and expenses, the mortgagors, who are already under severe financial strain, find it virtually impossible to reinstate. The initial referrals [by the mortgagees to the attorneys] thus appear to seal the mortgagors' fates. . . . [I]f [the plaintiff's] allegations are true, and they are in fact losing their homes largely because of attorney's fees, we find such conduct to be unconscionable."), discussed in HUD *supra* note 6 at 23.

[133] *See generally*, Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979) (explaining how legal entitlements provide bargaining power to parties, even without intervention by the courts to enforce those laws in the particular dispute).

back. Of course, any such costs will presumably be spread to all borrowers *ex ante*.

Under the status quo, mortgage disability insurance is already available on the private market.[134] Yet, only eight percent of our respondents indicated that they were currently unable to work because of a medical reason, and we do not know how many of these had such insurance. Even this small minority, who may have been eligible to receive such insurance benefits if they had bought such contracts *ex ante*, found themselves in foreclosure. Thus, to be effective, medical foreclosure insurance would likely need to be broader in scope, more widely held, and perhaps have quicker benefits than traditional disability insurance.

As an alternative to the insurance response, the government could create a law staying foreclosure proceedings during verifiable medical crises.[135] Similarly, during World War I, Congress was concerned about soldiers and sailors who were returning from combat to find that their homes had been foreclosed. Congress turned to then Major John Wigmore, later Dean of Northwestern University Law School and author of the renowned treatise, *Wigmore on Evidence*.[136] Wigmore drafted, and Congress passed, The Soldiers' and Sailors' Civil Relief Act of 1918, which stayed all home foreclosures against servicemembers while they were on active duty.[137] This Act expired at the

[134] *See e.g.*, STATE FARM MUT. AUTO. INS. CO., MORTGAGE DISABILITY INCOME INSURANCE, http://www.statefarm.com/insurance/disability/mortgdi.asp (last visited Oct. 28, 2007).

[135] Similarly, Kansas already has a law that stays wage garnishment proceedings during two months following a medical crisis that causes a loss of work. KAN. STAT. ANN. 60-2310(c) (2005) ("If any debtor is prevented from working at the debtor's regular trade, profession, or calling for any period greater than two weeks because of illness of the debtor or any member of the family of the debtor, and this fact is shown by the affidavit of the debtor, the provisions of this section shall not be invoked against any such debtor until after the expiration of two months after recovery from such illness."). It is unclear how valuable this provision is to a debtor, given that one who is not working is also not likely earning wages, and therefore has nothing to garnish.

[136] *See generally* Terry M. Jarrett, *The Servicemembers Civil Relief Act: Important New Protections for Those in Uniform*, 60 J. MO. B. 174 (2004).

[137] *Id.* The Act's mortgage foreclosure provisions are now codified at 50 U.S.C. app. § 533 (2000 & Supp. III 2005). "Mortgage lenders may not foreclose, or seize property for a failure to pay a mortgage debt, while a service member is on active duty or within 90 days after the period of military service unless they have the approval of a court. In a court proceeding, the lender would be required to show that the service member's ability to repay the debt was not affected by his or her military service." U.S. Dep't of Hous. & Urban Dev., Questions & Answers for Reservists, Guardsmen and Other Military Personnel, http://www.hud.gov/offices/hsg/sfh/nsc/qasscra1.cfm (last visited Oct. 7, 2007)

end of World War I, but Congress re-enacted it during World War II, without expiration, and has more recently expanded its reach.[138] There are two obvious motivations for this sort of stay provision. First is a sense of reciprocal obligation to those serving the country. If they are willing to put their lives on the line for us, the least we can do is protect their homes while they are gone. Second is a sense of sheer practicality and basic fairness. A soldier serving abroad is effectively incapacitated, unable to appear in court stateside, and with little control over his own finances.[139] Both of these points would seem to be particularly trenchant in a time of conscripted service, where soldiers are involuntarily removed from their stateside professions.

Homeowners suffering medical crises are obviously different in important ways compared to soldiers serving abroad. While there is not such a tangible sense of reciprocal obligation to homeowners as such, there may be a more philosophical commitment to reciprocity, in the sense of a social contract. After all, a medical emergency could strike any of us, and a catastrophic one could put nearly any of us at risk of losing our homes. There may be reasonable disagreement about how robust the social contract should be, but perhaps this is close to the bare minimum.[140] Even if our society is not willing to pay for your medical expenses, we may at least let you keep your home while you try to pay your own way. From the perspective of practicality and fairness, those in medical foreclosure share one feature with service members – their mortgage defaults are often involuntary. The positive law could distinguish between those who breach a contract voluntarily versus those who made a contract in good faith, but encountered obstacles that made performance impossible.[141] The means

(summarizing 50 U.S.C. app. § 533). The Act also has provisions for renters. *See* 50 U.S.C. app. §§ 531, 535. Likewise, the argument for protecting those in medical foreclosure could be extended to protect renters as well.

[138] The Act was amended in 2003, adding additional protections, including a mandate for the initial 90-day stay of proceedings rather than merely allowing court discretion in whether to impose the stay, as in the original act. Pub. L. No. 108-189, § 202(b)(1) 117 Stat. 2835.

[139] This concern for the servicemember's financial situation is evident in the Act's provision that a lender may move the court to lift the stay if it can show that the servicemember's finances are not in fact adversely impacted by his service in the military. *See* U.S. Dep't of Hous. & Urban Dev., *supra* note 137.

[140] *Compare* R. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997) (using the veil of ignorance to argue against a positive right to health care), *with* Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801 (1998) (using the veil of ignorance to argue for such a right).

[141] This is not to say that the law already makes such a distinction. *See* Richard A. Posner, *Common-Law Economic Torts: An Economic and Legal Analysis*, 48

test of the revised bankruptcy code reflects this sensibility; those who are able to repay their debts should do so, while the rest will be forgiven.[142]

Still, the proposed stay need not go all the way to discharging the debts of those in medical foreclosure, at least not for those whose medical crisis is temporary. The stay rule could operate on principles similar to a Chapter 13 bankruptcy, requiring borrowers to pay all of their disposable income towards their mortgage, but preventing the lender from taking the property during the medical crisis.[143] The unpaid portions of the mortgage payments would continue to accrue as secured debt, which would eventually be paid off by the borrower, or by a future purchaser of the property. Such a policy would nonetheless have a cost for lenders in cases where there is insufficient equity and an ultimate default, and this cost presumably would be passed on to the borrowers *ex ante*. If all borrowers are thereby paying the costs of protection from medical foreclosure, the system looks quite like the insurance program described above, only that it is now mandatory, avoiding the problems of bounded rationality.[144]

As an alternative to this form of mandated risk-spreading, the government could instead provide mortgage guarantees, loans, or grants that kick in only when a borrower avails himself of the medical tolling provisions.[145] For example, the Pennsylvania Foreclosure Pre-

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ARIZ. L. REV. 735, 745-46 (2006) (addressing wrongfulness and the strict liability components of contract law).

[142] 11 U.S.C. § 707. This test is a crude measure of ability to repay debts because it is retrospective, rather than prospective.

[143] Of course declaring bankruptcy is also an option, but bankruptcy may be unnecessarily drastic, expensive, and consequential for these homeowners. *See generally* Jacoby, *supra* note 108 (discussing the consequences of medical-related debt and assessing alternatives to bankruptcy in the health enviroment). A lighter weight, more tailored solution could be more efficacious. As noted above, bankruptcy is particularly unhelpful for those who have secured their debts with their homes. *See supra* notes 108-114 and accompanying text.

[144] *See* Schill, *supra* note 8, at 490 ("[M]ortgagor protection laws [function] as a form of insurance against the adverse effects of default and foreclosure. Viewed in this way, mortgagor protections might promote economic efficiency, even though, as an *ex post* matter, they are not frequently exercised by borrowers."). Schill also provides empirical evidence that mortgagor protections, such as prohibitions on deficiency judgments and statutory rights of redemption, have a modest effect on interest rates. *Id.*

[145] One advantage of requiring mortgage lenders to spread the costs of this stay provision, rather than the federal and/or state governments, is that lenders would only spread the costs to other homeowners. If the federal government were to guarantee these loans using their general treasuries, it would have the redistributive effect of forcing renters who are taxpayers to further subsidize homeowners (as they currently do with the various tax subsidies for homeowners). This inequity could be minimized

vention Act 91 of 1983 includes a Homeowners' Emergency Mortgage Assistance Program (HEMAP), which provides a temporary stay of foreclosure proceedings so that homeowners experiencing temporary financial disruptions can apply for special loans that cover their mortgage payments for up to 24 months or $60,000.[146] In its first twelve years in existence, the program has disbursed $384 million to 37,100 homeowners, out of 145,500 applications, and the program recoups its expenses through loan repayments and secondary liens, along with state appropriations.[147] Further study may reveal that this program is an effective model for legislation nationwide.

Methodologically, this entire study is merely a preliminary approach to the collection of empirical data about the causes of mortgage foreclosures, and will need to be replicated, and expanded in future studies. Notwithstanding all the knowledge that can be gleaned by inferential statistics, we found that a great deal can be learned by simply asking homeowners about the causes of their foreclosures. Although the respondents may be susceptible to various biases, and may lack important macro-level information available to social scientists, these homeowners are, at a practical level, in the best position to know what happened to them and what it means to them. Allowing them to tell their stories, and then listening, is a way of enfranchising them in the policymaking process. Future work needs to develop higher confidence that the respondents are representative of all those in foreclosure, and that the study does not suffer from a self-selection bias of respondents.

Altogether, these findings suggest that the standard account of mortgage foreclosure is missing a large portion of the story. Mortgage foreclosures are not just the results of bad loans, bad properties, or bad borrowers. Instead, many mortgage foreclosures are the result of unpredictable medical disruptions that impact both the incomes and the expenses of family finances.

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if renters also received some protections from medical evictions in a similar program.

[146] Pennsylvania Foreclosure Prevention Act 91 of 1983, 35 PA. STAT. ANN. §§ 1680.401c, .405c(f) (West 2003); Pennsylvania Housing Finance Agency, Pennsylvania Foreclosure Prevention Act 91 of 1983 – Homeowners' Emergency Mortgage Assistance Program (HEMAP), http://www.phfa.org/consumers/homeowners/hemap.aspx (last visited Oct. 11, 2007).

[147] Pennsylvania Housing Finance Agency, *supra* note 146; Cmty. Affairs Dep't, Fed. Reserve Bank of Phila., *Homeowner's Emergency Mortgage Assistance Program (HEMAP)*, TECHNICAL BRIEFS, Nov. 2006, *available at* http://www.phil.frb.org/cca/capubs/tech-brief_nov-2006.pdf.

Opening Statement of Senator Sessions

Hearing: "Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?"

Mr. Chairman, I appreciate you holding this hearing. The proper functioning of our bankruptcy laws is a very appropriate thing for us to consider.

There are individuals who are unable to pay their medical bills through little or no fault of their own, and bankruptcy does provide relief. But, Ms. Furchtgott-Roth contends in a recent article entitled *The Healthcare Bankruptcy Myth* that "fewer than one percent of Americans enter bankruptcy each year. Of those, only three to five percent are plausibly bankrupt due to medical debt. These numbers present the inconvenient truth that our health system is not leading to bankruptcy in America." This tells me that S.1624, the Medical Bankruptcy Fairness Act, is probably unnecessary.

I believe that the bill is not only unnecessary, but that it is also bad policy. As drafted, S.1624 would negatively impact the operation of our bankruptcy laws and the financial stability of our healthcare providers.

For instance, the bill would exempt people with certain medically-related characteristics from the bankruptcy "means test." The means test, now in force, already assures that needy debtors are allowed to avoid paying their debts. There is no valid reason to exclude individuals from the means test as it exists under current law. Needy debtors need not worry about the test because all debtors earning below the median income for their state are already exempt. As Professor Todd Zywicki noted in his 2005 article entitled *Bankrupt Criticisms*,

> "roughly 80 percent of bankruptcy filers earn below their state median income, and so will get tossed out of the means-test immediately. For that 80 percent—roughly 1.2 million of the 1.5 million bankruptcy filers [in 2004]—the means test will be completely irrelevant. They will be permitted to file Chapter 7 bankruptcy . . . . Roughly half of the remaining 20 percent of filers won't be able to repay enough of their debt to meet the repayment criteria, so they will be dropped out as well and permitted to file [Chapter 7]. So in the end, only the highest-income filers with the largest repayment capacity will be affected."

Therefore, the means test does not keep people who are truly unable to pay their bills from obtaining a discharge, it only requires those people who *can* pay a portion of their debts to pay the portion the court finds they are able to pay.

I would remind my colleagues that the means test currently allows several avenues for people with medical debts to avoid dismissal under that test. First, the means test specifically allows deductions for reasonably necessary health and disability insurance expenses and for payments

necessary to support an elderly, ill, or disabled household member. That means amounts spent for these purposes will be subtracted from the income of the debtor, which is used to determine his eligibility for Chapter 7 under the means test. Not only that, but a debtor who "fails" the means test by having a high income can still rebut the presumption of abuse by showing "special circumstances." Section 707(b)(2)(B) specifically lists "a serious medical condition" as such a special circumstance. Unusually high medical debts certainly are a special circumstance. Therefore, the present law already seems to adequately provide for the problem this bill seeks to address.

In addition to exempting debtors from the means test, this bill would also excuse debtors from undergoing consumer credit counseling before filing bankruptcy. The debtor would be excused from such counseling even in cases where the medical debt is not the true cause of the debtor's financial difficulty. If this bill passes, any debtor who qualifies as a "medically distressed debtor" will be excused from undergoing beneficial credit counseling, even if what actually landed him in bankruptcy was his entirely reckless borrowing.

The credit counseling requirement is intended to educate debtors on their alternatives to bankruptcy and help them avoid the negative consequences of a bankruptcy filing whenever possible. The Federal Trade Commission's website describes pre-bankruptcy consumer credit counseling as follows:

> "[a] pre-bankruptcy counseling session with an approved credit counseling organization should include an evaluation of [the debtor's] personal financial situation, a discussion of alternatives to bankruptcy, and a personal budget plan. A typical counseling session should last about 60 to 90 minutes, and can take place in person, on the phone, or online. The counseling organization is required to provide the counseling free of charge for those consumers who cannot afford to pay. If [the consumer] cannot afford to pay a fee for credit counseling, [he may] request a fee waiver from the counseling organization before the session begins. Otherwise, [he] may be charged a fee for the counseling, which will generally be about $50, depending on where [he] lives, the types of services [he] receive[s], and other factors. The counseling organization is required to discuss any fees with [the debtor] before starting the counseling session."

I think credit counseling sessions are of value to consumers, and that the requirement to undergo them does not impose a substantial burden on individuals wishing to file bankruptcy. I also think this bill's removal of that protection would cause consumers to file unnecessary bankruptcy petitions simply because they are unaware of their other options. Therefore, I think there is a risk that this bill would harm the very individuals it purports to help.

In fact, the only substantial benefits I can see from this bill are to the debtors' lawyers. Section 6 of the Medical Bankruptcy Fairness Act would prevent debtors from obtaining a discharge of the attorneys' fees they incurred in filing their bankruptcy petition under Chapter 7. I fail to see how that provision is related to medical debts. I also fail to see how that provision contributes to "medical bankruptcy fairness" where it makes it easier for a debtor to not pay bills owed to his doctor or local hospital, while, at the same time, forcing him to pay bills owed to his lawyer.

I see no reason that someone should be excused from paying their debts --debts which they have the ability to pay-- merely because those debts are owed to a healthcare provider. I would remind my colleagues that, for every debtor who gets a discharge in bankruptcy, there is a doctor, nurse, or hospital that has worked hard to provide needed treatment, but will never be paid for that hard work. The doctors, nurses and hospitals pass these losses on to their paying patients, resulting in higher healthcare prices and insurance premiums for all other Americans.

I recognize that a substantial number of people may be forced into bankruptcy by high medical debts; however, I do not think those cases justify changes to our bankruptcy laws. Mr. Chairman, I thank you again for holding this hearing. I think it is important that we, in this committee, keep a careful eye on how our bankruptcy laws are functioning.

Evaluating the Effectiveness of Credit Counseling

Phase One:
The Impact of Delivery Channels for Credit Counseling Services

(May 31, 2006)

by

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Evaluating the Impact of Delivery Channels for Credit Counseling Services

Phase I

Executive Summary

Objective

Phase 1 of the study developed several objective measures of counseling effectiveness and used them to determine whether effectiveness is influenced by delivery method (in-person counseling vs. telephone counseling).

The Sample

Ten credit counseling agencies were selected to participate in the study through a competitive grant proposal process. Several agencies provided counseling only over the phone, while others focused on face-to-face counseling sessions, and still others offered a combination of delivery channels. What they all have in common is an emphasis on client education and identification of the cause of underlying financial problems.

Participating agencies contributed data on over 70,000 clients who received an initial counseling session during March-April, 2003. Three years of credit report data (credit report attributes and credit scores in March 2002, March 2003 and March 2005) were appended to the client data in the initial sample by the national credit reporting agency Trans Union. All personally identifiable information was removed from client records before the data files were delivered to the research team. After dropping cases for which a match was not possible for all three years, the resulting analysis sample contained detailed credit report data and information from the initial counseling interview for 59,972 clients.

For this particular pooled sample, the most common form of the delivery channel is the telephone (67.7% of clients) followed by in-person delivery (22.6%) and Internet delivery (9.7%). Note that these proportions reflect the flow of business in early 2003 and may well be different at these same agencies today. Because Internet counseling was not consistently defined across agencies in 2003, the Phase 1 analysis focused only on telephone and in-person clients.

Data provided by the agencies for clients in the sample reflect information gathered during the first "counseling interview" with the client. All of the agencies in our sample did a first interview lasting anywhere from 30 minutes to 75 minutes. The interview collected detailed budget and asset information and identified potential causes of the clients' financial problems. Options were discussed and the counselor made a recommendation to the client. The counselor's recommendation and a written action plan were part of the product delivered to the consumer. Options for many clients included a recommendation to enroll in an agency-administered debt repayment program called a Debt Management Plan (DMP). Consumers recommended for a DMP could choose not to enroll, but the DMP recommendation is a signal that the counselor thought the client was qualified.

Agencies provided data on the counselor's recommended action step for each client, as well as information on Debt Management Plans (DMPs) for those who started a plan. In this pooled sample, 62.1% of clients were recommended for a DMP, although that percentage varied widely across agencies from a minimum of 16.9% to a maximum of 77.1%. However, the proportion of clients who actually started a DMP was substantially smaller (29.8% overall), as was the range across agencies (16.9% to 39.1%).

Characteristics of Consumers at the Time of Counseling

- The decision to seek counseling is an important signal of subsequent credit problems. Credit bureau information available at the time of counseling does not yet reflect private information that many counseled clients possess regarding recent changes in their financial condition. Consequently, the act of seeking counseling is a valuable "early warning" indicator that facilitates early intervention.
    - Counseled borrowers are much more likely to declare bankruptcy during the two years following counseling, relative to consumers in a nationally representative sample (17.6% vs. 1.2%), and are much more likely to have a serious public derogatory record item added to their credit report: 23.4% vs. 2.6% (Table 17).
    - A counseled borrower's likelihood of having bankruptcy and negative public record items being added to their credit files during the two years after counseling is higher even after controlling for initial (2003) levels of a dozen credit bureau characteristics that are predictive of risk, including bankruptcy risk scores (Table 19).
- The credit profile of borrowers who choose face-to-face counseling is different from borrowers who use telephone counseling. It appears that consumers may be self-selecting into delivery channels based in part on their perception of the severity of their financial problems.
    - Consumers counseled in-person generally have a higher risk of future payment problems, as indicated by lower initial risk scores. They also have more accounts with positive balances, larger mortgage balances, fewer bank card accounts and less unsecured debt (Table 21).

Impact of Delivery Channel on Credit Experience after Counseling

- Controlling for credit bureau information, counselor experience, and the information collected by the counselor during the counseling session (as reflected in the counselor's perception of the client's primary cause of financial difficulty and the counselor's recommended plan of action) the delivery channel for the initial counseling session appears to have little impact on two indicators of the client's creditworthiness measured two years after the initial counseling.

- Measured two years after counseling, there is no statistically significant difference between either the bankruptcy risk score or new account delinquency risk score of telephone and face-to-face clients (Table 27).

- Face-to-face clients tend to be more likely to file for bankruptcy in the subsequent two years (Table 27).

- The counselor's recommendation conveys information about the client's future credit performance that is not otherwise observable through the credit report variables. Information obtained during the counseling interview regarding the primary cause of the client's financial difficulty is also predictive, especially when controlling for the full set of variables in the model (Table 27).

- These results are robust across the entire sample, as well as subsets of clients from agencies that offer clients a choice between telephone and face-to-face counseling.

- Examination of two additional outcome measures – total non-mortgage dollar balances and the total number of accounts that were 30 days or more delinquent during the prior 18 months – revealed mixed findings with respect to whether delivery channel is associated with differences in post-counseling experience.

  - Total non-mortgage balances of clients measured two years after counseling do not seem to be affected by the counseling delivery channel (Table 26).

  - Consumers who experience face-to-face counseling have a reduced number of delinquencies, as measured two years after the initial counseling (Table 26).

Relationship of DMP to Credit Experience after Counseling

- Consumers who were recommended for a DMP and chose to start payments had a significantly lower incidence of bankruptcy over the two years following counseling, and had higher bankruptcy and delinquency risk scores (signaling lower payment risk) at the end of the two-year period, holding other factors constant (Table 27).

  - Clients who were recommended for a DMP but chose not to start did not experience improved bankruptcy and delinquency scores.

  - Clients who were not recommended for a DMP but ended up starting one anyway (possibly because they addressed other problems in order to qualify for a DMP) experienced improved delinquency risk scores two years later, relative to DMP non-starters, but no change in bankruptcy risk scores.

- Further analysis indicates no significant difference in the positive effect of an engagement in a DMP across delivery channels. DMP clients in both the telephone and in-person delivery groups experienced improvement in risk scores (Table 28).

Caveats

Several caveats to these findings should be noted. First and foremost, because the sample of participating agencies was not selected to be representative of industry-wide practices, the results cannot be considered representative of the typical experience of counseled consumers nationwide. Instead, they reflect what is obtainable from a group of agencies that emphasize client education and identification of the underlying cause of financial problems. The fact that telephone and face-to-face delivery of counseling services appear to generate equivalent outcomes for consumers in this sample suggests that, when done well, the two delivery channels can be equally effective.

We have presented results on four separate indicators of post-counseling outcomes for consumers, measured two years after the initial counseling visit. Two of these indicators (a commercially available bankruptcy risk score product; a commercially available new account delinquency risk score product) represent general measures of creditworthiness. Two indicators (total non-mortgage balances; number of accounts delinquent) reflect specific margins of credit usage. In addition, we also provide results on the incidence of bankruptcy during the two years following counseling. While these indicators examine the consumer's credit experience from a variety of angles, other measures of the impact of the counseling experience would help to provide a more comprehensive picture. In particular, survey evidence on consumer attitudes, knowledge gained, and perceived financial stress, pre and post-counseling, would augment the objective measures of consumer credit performance and provide a more complete picture of counseling's impact.

It would also be helpful to extend the post-counseling observation period for the sample to see if differences emerge in the credit bureau data for telephone and face-to-face clients. For those clients for whom counseling does change their borrowing and payment behavior, two years may not be enough time for the change to be fully reflected in their credit reports and credit scores, especially if prior financial distress was severe and its impact was not yet reflected in the credit report at the time of counseling.

There is some evidence that consumers' choice of delivery channel is associated with their credit usage patterns and resulting risk profile prior to counseling. The analysis in this report accounted for these differences to the extent allowed by the available data. However, a more detail assessment of borrowers at the time of the initial counseling, either during the interview itself or through supplemental survey work, would allow for more precise controls for this self-selection. Controlling for self-selection would help determine if the equivalence in outcomes across the telephone and face-to-face delivery channels indicated equal effectiveness or was an artifact of initial client characteristics.

The results on the role of Debt Management Plans are particularly intriguing, but self-selection may be partly responsible. Clients who start DMPs outperform all other counseling clients on all of our outcome measures. Admittedly, clients who were recommended for DMPs are in better financial shape than clients who do not qualify. But, the evidence also indicates that between two borrowers who are recommended for a DMP (i.e., borrowers for whom a DMP is both a

workable option and the best option), the borrower who actually starts payments in a DMP fares significantly better on all outcome measures at a point two years after counseling. Perhaps there is some residual self-selection effect driving this result (e.g., borrowers who make a commitment to start a DMP are more motivated to repay than borrowers that do not). Alternatively, perhaps the DMP experience itself (e.g., budgeting to make regular DMP payments; continued interaction with and reinforcement from the counseling agency) generates the improvement in the outcome indicators. Given the significantly improved credit profiles for clients who do start DMPs, this phenomenon deserves closer study.

Evaluating the Impact of Delivery Channels for Credit Counseling Services

by

Michael Staten and John Barron

Introduction

In 2004 ten credit counseling agencies were selected through a competitive proposal process to participate in an empirical study of the effect of credit counseling on long-term borrower behavior. This multi-year project is jointly sponsored by the Consumer Federation of America and American Express with the objective of identifying best practices in the counseling industry and quantifying their impact on consumers. The study will examine the effectiveness of face-to-face, telephone and Internet counseling across all types of consumer clients, including those who subsequently enroll in a DMP and those who receive financial counseling only or recommendations for legal and other assistance.

Within each of the three major categories of counseling delivery channels, the study will consider how different approaches to the timing, duration and content of counseling influence client outcomes. Effectiveness of counseling will be gauged by using credit bureau data to examine the credit profile of counseled clients at the time of the initial counseling session and subsequently at points two or more years following counseling.

The study has been divided into two phases. Phase 1 focuses on an examination of the outcomes of prior counseling activities. The advantage of this retrospective analysis is that we need not wait several years to identify counseling outcomes. A disadvantage is that archived data on individuals who received counseling in the past may not be sufficiently rich to clearly identify the effects of counseling, as opposed to other client characteristics that may also influence subsequent client behavior. A planned Phase 2 will modify the sample design to collect even more detailed information on incoming counseling clients and the treatment they receive, and follow these individuals over time.

For Phase 1 of the project, participating agencies supplied detailed data from the counseling "intake" interview on more than 70,000 clients who were counseled during early 2003. The following report presents some of the key findings of the Phase 1 analysis in terms of client credit profiles and payment experience over the two year period following the initial counseling. The findings suggest several issues that should be considered when designing Phase 2 of the study.

The report is organized as follows. Section I contains several tables that describe the data received from the ten counseling agencies and the composition of the pooled sample of clients

(e.g. distribution of clients across delivery channel, cause of financial problems, and counselor recommendation).

Section II presents summary measures of the credit bureau profile of counseled clients in the sample, and how they compare (around the time of initial counseling) with a separate, nationally representative sample of all consumers with credit reports. By pooling the sample of counseled consumers with the nationally representative sample, we examine how differences across individuals in key credit bureau variables (especially risk scores) can be used to predict which consumers will seek counseling services.

Section III utilizes the credit bureau data to compare the counseled group vs. the national sample in terms of the incidence of bankruptcy and other derogatory public record information during the two years following counseling, as well as changes in risk scores. Perhaps not surprisingly, we find that the very act of seeking out counseling is an important signal of subsequent credit problems. Individuals who seek counseling reveal themselves to be in financial stress, and that financial stress is often not fully captured by concurrent credit bureau data.

Section IV examines observable differences across counseled clients that may lead them to choose one method of counseling delivery vs. another. We use multivariate statistical (Probit) models to identify predictors of the choice of telephone versus face-to-face counseling. The results identify systematic differences in the clients who gravitate toward one channel vs. another. These results are useful for interpreting subsequent performance differences in the two groups during the years following counseling.

Section V reports the multivariate analysis that identifies the effect of counseling channel on subsequent credit behavior, controlling for factors identified in Section IV that appear to affect the choice of counseling delivery method. The analysis introduces various client performance measures drawn from the credit bureau data. It provides an initial look at how an individual's credit experience during the two years following counseling is related to variables that were observable at the time of counseling, including dimensions of their counseling experience. A concluding Section VI offers caveats and further discussion of the primary findings.

Section I: Counseling Agency Data

A total of 34 agencies submitted grant proposals in response to the Request For Proposal (RFP) that was distributed by American Express to 600+ agencies in August 2004. A review committee consisting of representatives from American Express, Consumer Federation of America and Georgetown University evaluated the proposals and met in October 2004 to select finalists. From the group of 34 respondents, 10 agencies were selected as grant finalists. Finalists were those agencies that were responsive in all of the required areas in the RFP, and received high ratings in the subjective areas of evaluation (data capture ability; description of the quality of their programs; evidence of innovative programs). All agency financial reports were screened for evidence of potential conflicts of interest or other problems of the type being investigated by the U.S. Internal Revenue Service. Evidence of such problems (e.g., documented

outsourcing of back-office tasks to for-profit companies owned by agency Board members) negatively influenced the overall ranking of the agency. In addition, the proposal review committee used information on agency size and scope of operations (especially the percentage distribution of clients across counseling delivery channels) to select the finalists to achieve representation across several key dimensions of the sample design, as discussed in greater detail below. Site visits were conducted between November 1 and December 20, 2004 for each of the agency finalists. Visits included opportunities to listen to ongoing counseling sessions and intake calls, either "live" or pre-recorded as part of the agency's quality assurance program.

The ten agencies that emerged from this process as participants in the study were Auriton Solutions (Roseville, MN), ClearPoint Financial Solutions, Inc. (Richmond, VA), Consumer Credit Counseling Service of Greater Atlanta, Inc. (Atlanta, GA), Consumer Credit Counseling Service of Los Angeles (Los Angeles, CA), Consumer Credit Counseling Service of Montana (Great Falls, MN), Consumer Credit Counseling Service of North Central Texas (McKinney, TX), InCharge Debt Solutions (Orlando, FL), LSS Financial Counseling Service (Duluth, MN), Novadebt (Freehold, NJ), and Money Management International (Houston, TX). Some are phone specialists, some do just face-to-face counseling, some do both. A number of agencies offer some form of counseling through the Internet. At least one agency has a unique "crisis management" approach to the client; others utilize a somewhat more scripted approach. What they all have in common is an emphasis on client education and identification of the cause of underlying financial problems.

In thinking about the sample, it is important to realize that the primary goal of Phase 1 is not to assess how a *nationally representative* sample of counseled clients performs over time. Rather, *the objective is to utilize the experience of agencies that appear to be high-quality providers in order to see if, when done well, counseling makes a difference, and to identify whether effectiveness is influenced by delivery method.*

Data in the sample reflect information gathered during the first "counseling interview" with the client. All of the agencies in our sample conducted initial client interviews lasting anywhere from 30 minutes to 75 minutes. The interview collected detailed budget and asset information and identified potential causes of the clients' financial problems. Options were discussed and the counselor made a recommendation to the client. The counselor's recommendation and a written action plan were part of the product delivered to the consumer. This definition of the "first counseling session" or "intake interview" was communicated to all participating agencies.

One option that was offered to many clients was enrollment in an agency-administered debt repayment program called a Debt Management Plan (DMP). Consumers recommended for a DMP could choose not to enroll, but the DMP recommendation is a signal that the counselor thought that customer was qualified.

Each agency was asked to provide information for all individuals who received a first-counseling session during March and April of 2003. A match of the counseling data to credit bureau data drawn from the second quarters of 2002, 2003, and 2005 was attempted. To maintain confidentiality, these matches were performed by one of the three major U.S. consumer reporting agencies, Trans Union, LLC (TU). Each agency sent their files directly to TU; TU then matched

based on available personal identifiers and sent the matched data, stripped of all unique personal identifiers, to the project research team at the Credit Research Center (CRC), Georgetown University.

For about 10,000 clients, a successful match across all three years could not be made. Attempts to match failed for a variety of reasons, but the greatest dropout occurred when the agency did not collect the Social Security Number of the individual being counseled. Limited credit histories at the time of counseling also appeared to account for a number of dropouts. Using data collected by the agencies where available, the average size of unsecured debt and the number of unsecured creditors was substantially lower for individuals who could not be matched to credit bureau data

Table 1 indicate the total number of observations within the 2003 time period that TU attempted to match and the percent that could not be matched to credit bureau data for all three years (2002, 2003, and 2005). Overall, 61,476 clients (87%) were matched to credit bureau data for all three years. The extent of matching was similar across agencies with the notable exception of Agency B. For this agency, two-thirds of the clients could not be matched to credit bureau data.

The credit bureau provided a number of attributes for each individual. Of particular interest are two types of credit scores provided. Both scoring products are risk management tools that TU markets to creditors and other firms making credit-related decisions. One reflects the risk of a serious delinquency on any account (equivalent in concept and roughly equivalent in scaling to the widely-reported FICO score product developed by Fair Isaac, Co.), while the second reflects the risk of bankruptcy. For the set of individuals that were matched to credit bureau data, the credit bureau data did not provide a complete set of risk scores (i.e., both scores for 2002, 2003 and 2005) for 2.4% of the clients.[1] The final column in Table 1 indicates the distribution across agencies of the 59,972 clients for whom a complete set of credit reports and credit risk scores were available for subsequent analysis.

[1] Note that there is no clear pattern to individuals missing such scores with respect to either the delivery channel or the counseling recommendation.

Table 1: Counseling Observations Dropped From Analysis Due to Incorrect Time Period, Inability to Fully Match to Credit Bureau Data, Or Missing Risk Score

Agency	Percent Dropped Because Visit Occurred Outside Early 2003 Period	Percent Dropped Because Not Fully Matched to Credit Bureau Data	Percent Dropped Because Of Missing Risk Score
A	0.0%	6.0%	2.3%
B	0.0%	66.1%	3.7%
C	14.4%	12.8%	3.2%
D	6.5%	6.2%	2.1%
E	0.0%	4.2%	2.2%
F	5.0%	18.9%	2.8%
G	0.0%	7.7%	2.3%
H	23.3%	9.0%	7.5%
I	10.7%	24.5%	3.4%
J	2.6%	20.0%	3.2%

Starting Number of Observations	72,253	Starting Number of Observations	71,003	Starting Number of Observations	61,476
Of These, Number Within 2003 Time Period	71,003	Of These, Number Matched to Credit Bureau Data	61,476	Of These, Number With Risk Score	59,972
Percent Dropped	1.7%		13.4%		2.4%

The sample drops 1.7% of the cases when the date of the initial counseling did not occur as specificed by the sampling instructions. For 5 of the 10 agencies, these were cases that were not initiated during the March 2003 to April 2003 period. For one agency, these were cases that were not initiated in March, April, or May 2003. The other four agencies had no observations outside the designated time span. We did retain the observations when the counseling date was not available. For two agencies, this was a sizable proportion of their total observations (i.e., 28% and 62% of their observations). Note that 22 of the 59,972 observations did not provide information on the delivery channel - these observations are omitted from subsequent analysis, leaving 59,950 observations.

Table 2 divides counseling clients by the delivery channel for the initial interview. Two agencies provided only telephone counseling, and a third was predominately telephone with less than 5 percent of clients counseled face-to-face. At the other end of the delivery spectrum, two agencies offered primarily face-to-face or internet counseling sessions. The remaining five agencies offered a combination of delivery channels for counseling. For this particular pooled sample, the most common form of the delivery channel is the telephone. However, recall that our sample is not a representative sample of individuals who seek counseling. In particular, the sample is dominated by large volumes of clients from two agencies, one of which does telephone counseling exclusively.

Table 2: Counseling Delivery Channels Across Agencies In Sample
(10 Agencies: 59,950 Observations)

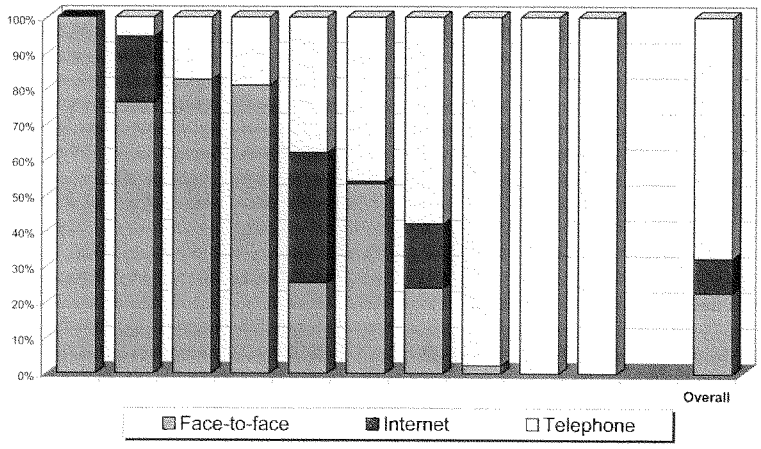

Table 3 indicates differences across the agencies in the recommendations that arose from the counseling session. Note that one agency (E) not only did not distinguish between referral to other services and referral to legal assistance but also did not distinguish between either type of referral and financial counseling only. Table 3 indicates large differences in the extent to which counseling resulted in a debt management plan being proposed. However, when one considers the percent of clients who actually started a DMP (see the last column in Table 3), the differences across agencies are not as pronounced.

Table 4 reports the recommendation of the counselor by type of delivery channel. Note that as a percent of all counseling sessions, DMP recommendations were made least frequently for face-to-face counseling clients. Nevertheless, face-to-face sessions display the highest "conversion rate" in terms of percent of clients who start a DMP (see last row in Table 4).

Table 3: Counselor Recommendations Across Agencies and Percent of DMPs Started

Agency	*Self Manage/ Client Can Handle*	*DMP recommended*	*Financial Counseling Only*	*Referral to Other Agency/ Service*	*Referral to Legal Assistance*	*Not Available*	*Some DMP payments made*
A	3.7%	26.7%	64.8%	0.6%	4.2%	0.0%	16.9%
B	10.3%	59.6%	12.6%	2.2%	4.3%	11.1%	20.2%
C	14.2%	29.8%	41.4%	6.8%	5.6%	2.2%	31.1%
D	3.9%	51.7%	22.2%	15.6%	4.0%	2.7%	35.9%
E	5.3%	64.4%	0.0%	30.1%	0.0%	0.2%	36.3%
F	4.5%	43.2%	26.1%	6.9%	7.8%	11.5%	25.0%
G	5.2%	77.1%	1.1%	7.8%	4.8%	3.9%	27.4%
H	1.5%	32.8%	61.3%	0.0%	1.1%	3.3%	39.1%
I	0.0%	16.9%	83.1%	0.0%	0.0%	0.0%	16.9%
J	0.0%	34.4%	0.2%	0.0%	0.0%	65.5%	25.6%
Total	5.2%	62.1%	9.9%	13.9%	3.0%	5.9%	29.8%

Total number of observations is 59,950. With the exception of agency *I*, the category "DMP recommended" includes individuals who were offerred but chose not to enroll in a debt management plan. For two agencies (*A* and *J*), the variable indicating the number of DMP payments made was missing, so the existence of payments was infered from a variable indicating DMP status. The "self manage" category includes what various agencies refer to as "client can handle", "choose to self manage", or "self administer". "Not available" can be due to an incomplete session.

Table 4: Delivery Channel By Counselor Recommendation

Counselor Recommendation	Face-to-face	Internet	Telephone	Overall
Self Manage/Client Can Handle	6.6%	3.3%	5.1%	5.2%
DMP recommended	53.4%	71.9%	63.5%	62.1%
Financial Counseling Only	19.7%	17.8%	5.5%	9.9%
Referal to Other Agency/Service	10.7%	2.6%	16.6%	13.9%
Referral to Legal Assistance	4.9%	2.1%	2.5%	3.0%
Not Available	4.7%	2.3%	6.8%	5.9%
Overall	100.0%	100.0%	100.0%	100.0%
Some DMP payments made	32.9%	21.5%	29.4%	29.4%

Percentages are for 59,950 sample of counseling agency clients.

Table 5 summarizes the primary reason identified by the counselor for the credit difficulties of the individual seeking counseling, using nine broad categories. Note that one agency, agency *B*, provided no reasons. For the other agencies, there is largely agreement that the two most likely reasons are related to either a disruption in income or poor money management. While of value, these responses are subjective. It is not clear that different agencies, or even counselors within the same agency, use the same criteria in selecting a primary cause of credit difficulties. The Appendix indicates the various responses that were collected within each of the nine broad categories.

For the various "primary" reasons identified for credit difficulties, Tables 6A, 6B, and 6C indicate how those primary reasons distribute across counselor recommendations. In Table 6A, the percentages by reason sum to 100% across recommendations. In Table 6B, the percentages by recommendation sum to 100% across reasons. Table 6C displays the percent of individuals who start a DMP by primary cause of financial difficulty, subdivided by whether the client was recommended for a DMP. Note that 22,749 clients were not recommended for a DMP, but 3.6% of this group ended up starting a DMP. This can occur when a client's financial circumstances change subsequent to the initial counseling session, perhaps even as a result of the session (e.g., client sells an asset or obtains a part-time job to supplement income). The first column displays more detail on the "DMP start-rate" for this group, by primary cause of the client's financial distress. Similarly, the second column shows that 37,201 clients were recommended for a DMP, and 45.2% of this group actually started a DMP.

Table 7 indicates how the primary causes distribute across delivery channels. Interestingly, the primary cause for a client's financial problems does not appear to be critical in determining the type of delivery channel chosen. Table 8 provides information on the housing situation of those seeking counseling by delivery channel.

Table 5: Primary Causes of Credit Difficulties, As Identified by Counselor

	Agency										
Primary Reason	*A*	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*Overall*
DEATH/ILLNESS/INJURY/DISABILITY	9.6%		8.1%	7.9%	10.9%	6.8%	7.6%	15.5%	5.9%	13.5%	8.8%
FRAUD/LEGAL PROBLEMS/EXPENSES			0.5%	0.3%			0.5%	1.1%			0.3%
HOME/AUTO EXPENSES			3.8%	1.9%		0.4%	0.9%		0.7%		0.7%
INCOME LOSS/INSTABILITY	32.6%		27.5%	26.2%	40.1%	27.3%	33.5%	10.3%	27.7%	49.1%	33.9%
MARITAL/DOMESTIC PROBLEMS/SUPPORT	5.1%		4.7%	5.9%	4.9%	4.5%	4.8%	5.9%	0.1%	6.3%	4.8%
OTHER/NA	8.9%	100.0%	22.1%	20.6%	7.6%	12.1%	7.0%	45.8%	50.0%	20.4%	13.9%
POOR MONEY MGMT	43.5%		32.4%	36.1%	36.4%	48.1%	44.0%	21.0%	12.7%	10.6%	36.8%
SCHOOL EXPENSES	0.3%		0.7%	0.9%		0.1%	1.6%		3.0%		0.8%
SUBSTANCE ABUSE/GAMBLING			0.4%	0.2%		0.8%	0.1%	0.4%			0.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of observations											59,950

The various specific primary causes are summarized in terms of the above nine broad categories. See Appendix A for detail on category components

Table 6A: Primary Cause of Financial Difficulty, by Counselor Recommendation

	Counselor Recommendation							
Primary Reason	*Self Manage/ Client Can Handle*	*DMP recommended*	*Financial Counseling Only*	*Referal to Other Agency/ Service*	*Referral to Legal Assistance*	*Not Available*	*Total*	*Number of obs.*
DEATH/ILLNESS/INJURY/DISABILITY	3.7%	64.1%	8.1%	15.1%	3.7%	5.3%	100.0%	5,274
FRAUD/LEGAL PROBLEMS/EXPENSES	9.3%	70.4%	6.2%	6.8%	5.6%	1.9%	100.0%	162
HOME/AUTO EXPENSES	16.0%	54.9%	11.5%	12.2%	4.1%	1.4%	100.0%	419
INCOME LOSS/INSTABILITY	4.1%	65.7%	8.3%	14.2%	2.7%	5.1%	100.0%	20,312
MARITAL/DOMESTIC PROBLEMS/SUPPORT	4.8%	63.6%	9.9%	13.5%	3.2%	5.1%	100.0%	2,855
OTHER/NA	10.6%	30.9%	18.6%	16.3%	2.9%	20.7%	100.0%	8,345
POOR MONEY MGMT	4.4%	59.6%	8.6%	12.9%	3.1%	1.5%	100.0%	22,043
SCHOOL EXPENSES	7.6%	77.1%	9.3%	4.3%	1.4%	0.2%	100.0%	485
SUBSTANCE ABUSE/GAMBLING	9.1%	47.3%	16.4%	12.7%	14.5%	0.0%	100.0%	55
Overall	5.2%	62.1%	9.9%	13.9%	3.0%	5.9%	100.0%	59,950

The various specific primary reasons (causes) are summarized in terms of the above nine broad categories. See Appendix A for details

Table 6B: Primary Cause of Financial Difficulty, by Counselor Recommendation

	Counselor Recommendation						
Primary Reason	*Self Manage/ Client Can Handle*	*DMP recommended*	*Financial Counseling Only*	*Referal to Other Agency/ Service*	*Referral to Legal Assistance*	*Not Available*	*Overall*
DEATH/ILLNESS/INJURY/DISABILITY	6.2%	9.1%	7.2%	9.5%	10.8%	8.0%	8.8%
FRAUD/LEGAL PROBLEMS/EXPENSES	0.5%	0.3%	0.2%	0.1%	0.5%	0.1%	0.3%
HOME/AUTO EXPENSES	2.1%	0.6%	0.8%	0.6%	0.9%	0.2%	0.7%
INCOME LOSS/INSTABILITY	26.5%	35.8%	28.2%	34.5%	30.9%	29.3%	33.9%
MARITAL/DOMESTIC PROBLEMS/SUPPORT	4.4%	4.9%	4.8%	4.6%	5.0%	4.1%	4.8%
OTHER/NA	28.3%	6.9%	26.1%	16.3%	13.5%	48.9%	13.9%
POOR MONEY MGMT	30.8%	41.3%	31.8%	34.0%	37.5%	9.4%	36.8%
SCHOOL EXPENSES	1.2%	1.0%	0.8%	0.3%	0.4%	0.0%	0.8%
SUBSTANCE ABUSE/GAMBLING	0.2%	0.1%	0.2%	0.1%	0.4%	0.0%	0.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of observations	3,139	37,201	5,938	8,345	1,798	3,529	59,950

The various specific primary reasons (causes) are summarized in terms of the above nine broad categories. See Appendix A for details.

Table 6C: Percent Starting DMP by Primary Reasons Identified by Counselor For Credit Difficulties

Primary Reason	DMP Started: DMP not recommended	DMP Started: DMP recommended	Overall	Number of obs.
DEATH/ILLNESS/INJURY/DISABILITY	3.1%	49.3%	32.7%	5,274
FRAUD/LEGAL PROBLEMS/EXPENSES	10.4%	36.0%	28.4%	162
HOME/AUTO EXPENSES	3.7%	45.2%	26.5%	419
INCOME LOSS/INSTABILITY	3.5%	46.2%	31.5%	20,312
MARITAL/DOMESTIC PROBLEMS/SUPPORT	4.1%	44.0%	29.5%	2,855
OTHER/NA	1.9%	34.5%	12.0%	8,345
POOR MONEY MGMT	5.2%	45.6%	33.3%	22,043
SCHOOL EXPENSES	6.3%	36.9%	29.9%	485
SUBSTANCE ABUSE/GAMBLING	3.4%	46.2%	23.6%	55
Overall	3.6%	45.2%	29.4%	
Number of observations	22,749	37,201		59,950

The various specific primary reasons (causes) are summarized in terms of the above nine broad categories.

Table 7: Primary Causes Identified by Counselor For Credit Difficulties Across Agencies in the Sample

	Delivery Channel			
Primary Cause	*Face-to-face*	*Internet*	*Telephone*	*Overall*
DEATH/ILLNESS/INJURY/DISABILITY	8.2%	6.0%	9.4%	8.8%
FRAUD/LEGAL PROBLEMS/EXPENSES	0.4%	0.2%	0.2%	0.3%
HOME/AUTO EXPENSES	1.5%	1.0%	0.4%	0.7%
INCOME LOSS/INSTABILITY	30.4%	30.2%	35.6%	33.9%
MARITAL/DOMESTIC PROBLEMS/SUPPORT	4.9%	4.7%	4.7%	4.8%
OTHER/NA	15.8%	11.7%	13.6%	13.9%
POOR MONEY MGMT	37.5%	44.0%	35.5%	36.8%
SCHOOL EXPENSES	1.0%	2.1%	0.6%	0.8%
SUBSTANCE ABUSE/GAMBLING	0.3%	0.0%	0.0%	0.1%
Total	100.0%	100.0%	100.0%	100.0%
Number of observations	13,567	5,791	40,592	59,950

The various specific primary causes are summarized in terms of the above nine broad categories.

Table 8: Housing Situtation By Channel of Delivery for Sample Matched to Credit Bureau Files

Housing Situation	*Face-to-face*	*Internet*	*Telephone*	*Total Number*
Own	41.4%	33.5%	41.1%	24,235
Rent	34.1%	37.6%	41.1%	23,511
Live with Parents / Other	18.3%	0.5%	7.3%	5,467
Not Available	6.2%	28.4%	10.5%	6,737
Overall	100.0%	100.0%	100.0%	59,950

II. Credit Bureau Data

Credit bureau data provide an objective assessment of the client before and after the credit counseling experience. Based on credit data provided by TU, Table 9 provides a comparison between a nationally representative random sample of consumers ("national sample") and individuals in the counseling sample in terms of the total number of trades (accounts) with a positive balance and total balances across all trades. Not surprisingly, the average number of trades for individuals in the national sample is lower. Note that those seeking counseling hav both higher mean and median levels of total balances.

Table 9: Credit Bureau Variables for National Representative Sample Versus Credit Counseling Sample: Trades and Balances

	Number of trades with positive balance		Total balance across all trades (in 1,000s)	
Percentile	National Sample	Counseling Sample	National Sample	Counseling Sample
1%	0	0	$0	$0
5%	0	1	$0	$0
10%	0	1	$0	$2
25%	1	3	$0	$10
50%	3	6	$12	$31
75%	5	9	$76	$92
90%	8	12	$169	$161
95%	10	15	$240	$208
99%	14	21	$464	$334
Mean	3	7	$57	$62
Standard Deviation	3	5	$116	$80
Number of Observations	263,937	59,950	263,937	59,950
Percent of individuals with active/verified bankcard	71.6%	82.3%	71.6%	82.3%

Credit bureau variable names are AT29 and AT33; National sample credit bureau data from June, 2003. Counseling sample credit bureau data from March, 2003.

If we focus on consumers who have one or more active/verified bank card accounts, such accounts are more likely to exist for consumers in the counseling sample. Among individuals with active/verified bank card accounts, Table 10 indicates that the distribution regarding the number of accounts is similar across the two groups (national sample and counseled group). However, Table 10 also indicates that bank card account utilization (balance as a percent of credit limit) is clearly higher for the counseled group.

Table 10: Credit Bureau Variables for National Representative Sample Versus Credit Counseling Sample: Bankcard Use

	Number of active or active/verified bank cards		Percent of bankcard trades greater than 50% of limit	
Percentile	National Sample	Counseling Sample	National Sample	Counseling Sample
1%	1	1	0	0
5%	1	2	0	0
10%	2	3	0	33.3
25%	3	5	0	66.7
50%	6	7	0	100
75%	9	11	50	100
90%	14	15	100	100
95%	17	18	100	100
99%	25	25	100	100
Mean	7	8	27	79
Standard Deviation	5	5	38	29
Number of Observations	189,008	49,340	189,008	49,340
Percent of individuals with active/verified bankcard	100.0%	100.0%	100.0%	100.0%

Credit Bureau variable names are BC01 and BC30; National sample credit bureau data from June, 2003. Counseling sample credit bureau data from March, 2003.

Two risk scores were provided by the credit bureau. One measures the likelihood that a consumer will file for bankruptcy. The second score measures the likelihood of serious delinquency on a newly opened account. For both scores, a higher score indicates lower risk (i.e., either less likely to file for bankruptcy or less likely to become seriously delinquent on a newly opened account). Table 11 indicates that, on average across nearly 60,000 observations, individuals counseled in person have higher risk (i.e., have lower scores) of bankruptcy and serious delinquency. Closer examination reveals that among the five agencies (A, C, D, G, and H) that had significant numbers of clients counseled through in-person and telephone channels (as opposed to specializing in one or the other), bankruptcy risk scores for in-person clients were significantly lower (relative to telephone clients) for three of these five agencies and significantly higher for one. For delinquency risk scores, two of the five agencies had scores significantly

lower for clients counseled in person. Thus, there is some evidence that in-person clients at these five agencies were, on average, higher risk than their telephone counterparts. [Note: Agency *C* has a substantially higher average risk score for its telephone clients, relative to any other client subgroup in the sample. Possibly this is due to a targeted marketing effort or affiliation that attracts a group of clients who appear to be lower risk, at least as measured by the credit report around the time of initial counseling.]

Table 11: Average 2003 Credit Bureau Bankruptcy and Delinquency Risk Scores By Delivery Channel and Agency

		Face-to-face	*Internet*	*Telephone*	*Overall*
Agency					
A	*Bankruptcy Risk Score*	227	260	252	248
	Delinquency Risk Score	595	607	596	600
B	*Bankruptcy Risk Score*			232	232
	Delinquency Risk Score			580	580
C	*Bankruptcy Risk Score*	260	250	419	333
	Delinquency Risk Score	594	611	671	630
D	*Bankruptcy Risk Score*	220		210	219
	Delinquency Risk Score	580		573	579
E	*Bankruptcy Risk Score*			235	235
	Delinquency Risk Score			592	592
F	*Bankruptcy Risk Score*	268	212	207	255
	Delinquency Risk Score	603	590	589	600
G	*Bankruptcy Risk Score*	243	256	253	251
	Delinquency Risk Score	590	600	603	599
H	*Bankruptcy Risk Score*	278		252	273
	Delinquency Risk Score	597		590	595
I	*Bankruptcy Risk Score*	245			245
	Delinquency Risk Score	589			589
J	*Bankruptcy Risk Score*	261		233	234
	Delinquency Risk Score	596		589	589
Overall	*Bankruptcy Risk Score*	239	256	246	245
	Delinquency Risk Score	588	602	597	595

Sample includes only observations with credit bureau risk scores. Note that higher score indicates lower risk of bankruptcy. Total number of observations is 59,950

Table 12 indicates the differences in the risk scores between the counseling sample and the nationally representative sample of consumers. Table 12 indicates that the counseling sample has substantially lower bankruptcy and new account delinquency risk scores than the national sample. For instance, whereas around 50% of the national sample has a delinquency risk score over 740, less than 10% of the counseling sample has a delinquency risk score this high or higher. And, this difference occurs even though the national sample includes some individuals very similar to those in the counseling group.

Table 12: Credit Bureau Variables for National Representative Sample Versus Credit Counseling Sample: Risk Scores

	Bankruptcy Risk Score		New Account Risk Score	
Percentile	National Sample	Counseling Sample	National Sample	Counseling Sample
1%	15	5	424	419
5%	128	15	460	445
10%	143	37	498	470
25%	329	134	614	531
50%	693	180	742	588
75%	835	333	841	658
90%	959	522	880	723
95%	976	648	894	759
99%	987	870	908	843
Mean	599	245	718	595
Standard Deviation	294	190	139	95
Number of Observations	263,937	59,950	263,937	59,950
Percent of individuals with risk score	85.7%	97.6%	85.7%	97.6%

National sample credit bureau data from June, 2003. Counseling sample credit bureau data from March, 2003.

Credit bureau variables as predictors of decision to seek counseling

Individuals in the counseling group are clearly different from individuals in a nationally representative sample of consumers with credit reports. We now consider a wider array of factors that are associated with seeking credit counseling assistance. To do so, we combine the national credit bureau sample with the counseling sample to create a pooled dataset, and define a variable that equals one if the individual is from the counseling sample and zero otherwise. We then estimate a Probit model with the dependent variable indicating whether the individual is from the counseling sample.

For the pooled sample, 18.5 percent are directly identified as having sought counseling at approximately the same time as the credit bureau data was pulled. Of course, there are surely individuals within the national sample who also sought counseling during this period that are not identified. Their presence introduces measurement error that, among other things, can lead to a bias toward zero in our estimated coefficients. That is, an observed relationship between credit bureau variables and the choice of counseling must be stronger in this sample (relative to one in which there are no unidentified counseled consumers) to achieve statistical significance.

Table 13 presents the results for the Probit model estimation that includes as explanatory variables selected credit bureau variables as measures of credit profile and creditworthiness. Coefficients on the explanatory variables indicate the marginal effect of a change in the variable on the probability of being in the counseled sample. Table 13 indicates that individuals with lower risk scores, a higher number of trades with positive balances (both overall and bankcard), a greater utilization rate for bank cards, and larger numbers of delinquencies and inquiries are more likely to seek out counseling. Note that in Table 13, the coefficients indicate the marginal effect of a one unit change in the independent variable. For instance, an increase by 100 in the bankruptcy risk score (one unit) is predicted to decrease the likelihood of an individual seeking counseling by .0247 or 2.47%.

Table 13 also reports averages for the explanatory variables for the two samples (control and counseling) to provide the reader with a better idea of how the counseling sample differs from the nationally representative sample across various credit bureau variables.

Table 13: Probit Model of Factors Affecting Likelihood that an Individual in Credit Bureau Pooled Sample is From Counseling Agency Sample

	Coefficient in Probit Model (z-statistic)	Mean of variables for control sample (standard deviation)	Mean of variables for counseling sample (standard deviation)
Bankruptcy risk score (in 100s)	-0.0247***	5.99	2.45
	(65.13)	(2.94)	(1.9)
New account risk score (in 100s)	-0.0131***	7.18	5.95
	(14.26)	(1.39)	(0.95)
Total number of trades with balance > 0	0.0096***	3.39	6.61
	(35.65)	(3.24)	(4.53)
Total balance, non-mortgage trades (in 10,000s)	-0.0014***	1.74	2.92
	(7.41)	(4.16)	(3.43)
Total balance, mortgages (in 10,000s)	-0.0021***	3.99	3.28
	(23.88)	(10.07)	(6.56)
Number of bankcard trades	0.0004***	5.44	7.44
	(2.97)	(5.27)	(5.07)
Proportion of bankcard trades with balance over 50% of limit	0.1202***	0.19	0.65
	(53.04)	(0.34)	(0.4)
Number of non-installment trades over 50 % of limit	0.0106***	0.92	3.59
	(24.62)	(1.62)	(3.1)
Number of trades 30 or more days past due in last 18 mths	0.0077***	0.73	3.14
	(25.06)	(1.72)	(3.24)
Number of currently past due balances	0.0152***	0.18	1.19
	(24.58)	(0.66)	(1.77)
Number of inquiries in last 6 months	0.0041***	1.06	2.16
	(16.69)	(1.8)	(2.72)
Highest retail credit limit (in 1,000s)	0.0018***	1.47	1.29
	(5.73)	(2.28)	(1.89)
Number of observations	323,887	263,937	59,950

Not reported is a variable indicating missing values for the variable measuring the percent of bankcard trades with balance over 50%. This variable is not defined if an individual has no bank cards.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 14 suggests that another predictor of an individual seeking out counseling is a decline in the risk score over the preceding 12 months. Consumers who visited a counselor in 2003 experienced a median reduction in their bankruptcy risk score of 55 points, and a median reduction in their delinquency risk score of 26 points during the 12 months prior to their visit. By comparison, the median change in risk scores was at or near zero for consumers in the nationally representative sample over a different (longer) period, June 2003 to December 2004.

Table 14: Change in Credit Bureau Risk Scores During 12 Months Prior to Counseling

	Change in Bankruptcy Risk Score		Change in New Account Risk Score	
Percentile	Counseling Sample, March 2002 to March 2003	National Sample, June 2003 to Dec. 2004	Counseling Sample, Mar. 2002 to March 2003	National Sample, June 2003 to Dec. 2004
1%	-647	-503	-201	-161
5%	-455	-294	-144	-92
10%	-350	-204	-117	-60
25%	-189	-54	-72	-20
50%	-55	0	-26	2
75%	4	47	8	31
90%	81	158	40	67
95%	146	239	60	91
99%	317	424	101	141
Mean	-98	-10	-33	3
Standard Deviation	184	158	63	55
Number of Observations	59,950	263,937	59,950	263,937

Table 15 indicates how the changes in risk scores are related to both the counseling delivery channel and the subsequent counselor recommendation. Note that clients who are referred for legal assistance experienced the largest average decreases in risk scores during the prior year, while those deemed able to self-manage had the lowest average reduction in risk scores. Both relationships seem consistent with expectations. With respect to the channel of delivery, the average magnitude of the drop in risk score over the year prior to counseling was similar across channels.

Table 15: Change in Credit Bureau Risk Scores During 12 Months Prior to Counseling Visit, by Subsequent Counselor Recommendation And by Delivery Channel

		Face-to-face	*Internet*	*Telephone*	*Overall*
Self Manage/Client Can Handle	*Change in Bankruptcy Risk Score*	-50	-126	-96	-84
	Change in Delinquency Risk Score	-15	-22	-31	-26
	Number of Observations	897	191	2,051	3,139
DMP recommended	*Change in Bankruptcy Risk Score*	-99	-100	-102	-101
	Change in Delinquency Risk Score	-35	-32	-34	-34
	Number of Observations	7,250	4,165	25,786	37,201
Financial Counseling	*Change in Bankruptcy Risk Score*	-96	-93	-88	-93
	Change in Delinquency Risk Score	-34	-28	-30	-31
	Number of Observations	2,669	1,028	2,241	5,938
Referal to Other Agency/Service	*Change in Bankruptcy Risk Score*	-95	-99	-94	-94
	Change in Delinquency Risk Score	-34	-26	-32	-33
	Number of Observations	1,449	151	6,745	8,345
Referral to Legal Assistance	*Change in Bankruptcy Risk Score*	-116	-105	-117	-116
	Change in Delinquency Risk Score	-49	-48	-43	-46
	Number of Observations	664	121	1,013	1,798
Not Available	*Change in Bankruptcy Risk Score*	-56	-105	-92	-86
	Change in Delinquency Risk Score	-24	-40	-34	-32
	Number of Observations	638	135	2,756	3,529
Overall	*Change in Bankruptcy Risk Score*	-94	-100	-99	-98
	Change in Delinquency Risk Score	-34	-31	-33	-33
	Number of Observations	13,567	5,791	40,592	59,950

Section III: A Comparison of Outcomes: Counseled Clients vs. Nationally Representative Sample

In this section, we examine post-counseling changes in the incidence of negative public record items (including bankruptcy) of the counseled group, relative to a nationally representative sample of consumers. We also examine the post-counseling change in credit risk scores. The results must be viewed only as suggestive, however, because the time period used to measure performance for the counseled group (the 24-month period from March 2003 to March 2005) differs from the time period available for measuring performance of the national sample (the 18-month period from June 2003 to December 2004).

Table 16 indicates the changes in bankruptcy risk scores and new account delinquency risk scores for the counseling sample between March 2003 and March 2005, side-by-side with the comparable change for the national sample between June 2003 and December 2004. To account for the fact that those seeking counseling begin the period with significantly lower risk scores compared to consumers in the nationally representative sample, we divide individuals according to their initial score values in 2003. In particular, we separate the combined sample into deciles based on their risk score, and then measure the average subsequent change in the risk score for each decile.

The summary statistics reported in Table 16 indicate that among individuals with high initial risk scores, the subsequent drop in risk scores was especially large for individuals who sought counseling. In other words, controlling for the risk score of an individual as of 2003, the extent of the reduction in the risk score is greater for the counseling group over the following period as compared to the national sample. A simple regression analysis (not shown) indicates that, controlling for 2003 bankruptcy risk scores, the subsequent bankruptcy score for individuals in the counseling sample fell by approximately 59 points compared to the control group. Similarly, controlling for 2003 delinquency risk scores, the subsequent delinquency score for individuals in the counseling sample fell by 22 points compared to the control group. Though the differences are slightly less, similar results hold even if one excludes from the analysis those who subsequently filed for bankruptcy.

Table 16: Change in Credit Bureau Risk Scores, 2003 - 2005

			Change in Bankruptcy Risk Score			
Decile for 2003 Bankruptcy Risk Score (combined sample)	Minimum Score in Decile (2003)	Maximum Score in Decile (2003)	National Sample, June 2003 to Dec. 2004	National Sample Number of Observations	Counseling Sample, March 2003 to March 2005	Counseling Sample Number of Observations
1	0	135	56.8	18,342	62.6	16,332
2	136	169	45.0	18,442	35.5	11,692
3	170	269	61.6	20,408	15.7	12,019
4	270	427	37.8	22,145	-48.4	10,268
5	428	596	-4.2	26,901	-134.3	5,620
6	597	705	-26.1	30,496	-198.8	1,938
7	706	752	-18.7	31,649	-200.1	687
8	753	847	-34.2	31,503	-272.2	705
9	848	950	-64.0	32,159	-278.2	473
10	951	998	-59.6	31,892	-139.9	216
Mean/No. Obs.			-9.7	323,887	-8.3	59,950
			Change in New Account Risk Score			
Decile for 2003 Deliquency Risk Score (combined sample)	Minimum Score in Decile (2003)	Maximum Score in Decile (2003)	National Sample, June 2003 to Dec. 2004	National Sample Number of Observations	Counseling Sample, March 2003 to March 2005	Counseling Sample Number of Observations
1	402	490	24.7	23,891	33.9	8,579
2	491	552	12.0	20,338	6.5	12,337
3	553	606	9.0	19,023	-0.9	13,645
4	607	658	7.7	21,742	-17.0	10,497
5	659	702	6.3	25,400	-33.4	6,628
6	703	751	5.8	27,958	-47.1	4,759
7	752	805	4.0	29,710	-56.1	2,309
8	806	843	-3.2	32,135	-51.1	599
9	844	874	-7.1	31,869	-54.8	373
10	875	925	-12.8	31,871	-46.2	224
Mean/No. Obs.			3.3	323,887	-7.6	59,950

Table 17 displays results regarding change in public record items. For this analysis, we identified those consumers that had no public records evident in their 2003 credit report, either with respect to the broader range of derogatory public record items or more specifically bankruptcy. As Table 17 indicates, 93.6% of the national sample and 90.6% of the counseling sample had no public record of bankruptcy as of 2003. With respect to all types of derogatory

public records, 86.4% of the national sample and 81.3% of the counseling sample had no public derogatory reports in their credit file. Separate inspection revealed that, for the counseling group, the consumers who had no public records were similarly represented across delivery channels and counselors' recommendation. For individuals without derogatory public records (either bankruptcy or the more inclusive category) at the outset of the period, we then identified those who had one or more derogatory public record items (or bankruptcy filing) in March of 2005 for the counseling sample and in December of 2004 for the national sample.

Table 17: Change in Public Record Items, 2003 - 2005

	Public Bankruptcy Record		Public Derogatory Record	
Percentile	National Sample	Counseling Sample	National Sample	Counseling Sample
Percent with No Public Bankrupcty/Derogatory Records in June 2003	93.6%		86.4%	
Percent with No Public Bankrupcty/Derogatory Records in March 2003		90.6%		81.3%
Of Those with No Public Bankruptcy Record, Percent With Public Bankruptcy/Derogatory Record 18 months later	1.2%		2.6%	
Of Those with No Public Bankruptcy Record, Percent With Public Bankruptcy/Derogatory Record 24 months later		17.6%		23.4%

Note that 17.6% and 23.4 % of counseled clients, respectively, either subsequently filed for bankruptcy or had a derogatory public record (that included bankruptcy filing) within 24 months after the counseling experience. In contrast, for the national sample, 1.2% and 2.6 %, respectively, either subsequently filed for bankruptcy or had a derogatory public record (that included bankruptcy filing) 24 months after the counseling experience.

Table 12 indicated a substantial difference in risk scores for the counseling sample compared to the national sample. Clearly this can be one contributing factor that explains the differences in bankruptcy filing rates between the two groups reported in Table 17. However, even after controlling for risk scores at the outset, the regression model estimates displayed in Table 18 indicate that those who visited a counseling agency had an increased likelihood of a subsequent bankruptcy or derogatory public record. In Table 18, we consider specifications that include either one or both risk scores. In addition, recognizing that the likelihood of a bankruptcy filing may be non-linear in risk scores, and in particular that individuals with extreme values may be

different from others, we include as control variables two additional dummy variables for each risk score that equal one if the individual's risk score is in the lowest or highest decile.

The first two columns of Table 18 indicate that an increase in either an individual's bankruptcy risk score or an individual's delinquency risk score reduces the likelihood of subsequent bankruptcy, as expected. Recall that these commercial scores are scaled so that higher scores indicate lower risk. However, those with the highest scores (top decile) and those with the lowest scores (bottom decile) are even less likely to subsequently file for bankruptcy than predicted by a simple linear specification. The fourth and fifth columns of Table 18 indicate a similar finding for a derogatory event. Note that for both the bankruptcy and derogatory public record events, an individual in the counseling sample is more likely to experience a "bad" outcome, even after controlling for risk scores.

The third and sixth columns in Table 18 include both bankruptcy and delinquency risk score variables. There are two interesting features to note regarding these results. First, it remains the case that individuals in the counseling sample are more likely to experience either a subsequent bankruptcy or derogatory event. Second, with both bankruptcy and delinquency risk scores in the specification, an increase in the delinquency risk score, holding constant the bankruptcy risk score, is associated with an increase in the likelihood of a bankruptcy for those not in the bottom decile.

Tables 19 and 20 further illustrate that, controlling for initial risk scores, counseling is an important signal of subsequent credit problems even after adding a number of additional control variables that have been identified as important components of risk scores. Table 19 examines the link between the decision to seek counseling and a subsequent bankruptcy event or a public derogatory event. Table 20 examines the link between the decision to seek counseling and subsequent risk scores.[2]

Individuals in the counseling sample reveal themselves to be in financial distress. Tables 19 and 20 show that financial stress is not fully captured by the credit bureau data at the time of counseling. Among other implications, this characteristic of counseled clients makes it difficult to isolate the value of counseling itself because contemporaneous credit bureau information often doesn't immediately capture the private information that induces individuals to seek counseling. Because creditors typically only report updates on account activity to the credit bureau once per month, there is almost always a lag time between a credit event and the time it is first reflected on the credit report. New financial distress takes time to manifest in credit behavior (e.g., delinquency), and additional time to appear on a credit report.

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[2] Table 19 considers restricted samples of individuals with no bankruptcy filing event (column 1) or no public derogatory event (column 2) in 2003. Table 20 provides predictions of subsequent risk scores for restricted and full samples. For the counseling sample, two years separate the 2003 independent variables and the subsequent event. For the national sample, one and one-half years separate the 2003 independent variables and the subsequent event.

Table 18: Predicting Likelihood of Actual Bankruptcy Filings and Public Derogatory Events Based on Credit Bureau Risk Scores and Counseling Event (Probit Model)

	Bankruptcy Event			*Derogatory Event*		
	Bankruptcy scores only	Delinquency scores only	Bankruptcy and Delinquency scores	Bankruptcy scores only	Delinquency scores only	Bankruptcy and Delinquency scores
Counseling group indicator	0.0663***	0.1052***	0.0566***	0.0697***	0.1109***	0.0664***
	(92.39)	(111.89)	(85.44)	(77.98)	(104.20)	(75.15)
Bankruptcy risk score: 2003 (in 100s)	-0.0049***		-0.0060***	-0.0107***		-0.0091***
	(55.17)		(50.96)	(79.04)		(50.86)
Bankruptcy score in bottom 10% of combined sample: 2003	-0.0036***		-0.0031***	-0.0041***		-0.0027***
	(8.86)		(8.06)	(5.72)		(3.84)
Bankruptcy score in top 10% of combined sample: 2003	-0.0103***		-0.0075***	-0.0084***		-0.0053**
	(5.36)		(3.92)	(3.67)		(2.30)
Delinquency risk score: 2003 (in 100s)		-0.0083***	0.0035***		-0.0206***	-0.0028***
		(36.35)	(14.79)		(63.84)	(7.30)
Delinquency score in bottom 10% of combined sample: 2003		-0.0103***	-0.0038***		-0.0113***	-0.0049***
		(18.74)	(8.04)		(13.23)	(6.01)
Delinquency score in top 10% of combined sample: 2003		-0.0164***	-0.0114***		-0.0177***	-0.0159***
		(9.97)	(9.47)		(8.20)	(8.73)
Observations	301492	301492	301492	276865	276865	276865

Sample restricted to clients that had no record of a public bankruptcy filing in 2003 (first three columns) or no record of a public derogatory event (second three columns). The proportion of individuals who subsequently had a record of a public bankruptcy filing is .042 and the proportion of individuals who subsequently had a record of a public derogatory event is .063.

Coefficients indicate marginal effects. * sigoificant at 10%; ** significant at 5%; *** significant at 1%

Table 19: Predicting Likelihood of Actual Bankruptcy Filings and Public Derogatory Events Based on Credit Bureau Data and Counseling Event (Probit Model)

	Bankruptcy Event	*Derogatory Event*
Counseling group indicator	0.0414***	0.0510***
	(67.94)	(59.35)
Bankruptcy risk score (in 100s)	-0.0041***	-0.0064***
	(34.41)	(33.79)
Bankruptcy score in bottom 10% of combined sample	-0.0038***	-0.0051***
	(10.20)	(7.31)
Bankruptcy score in top 10% of combined sample	-0.0072***	-0.0052**
	(3.84)	(2.29)
Delinquency risk score (in 100s)	0.0012***	-0.0061***
	(4.27)	(12.77)
Delinquency score in bottom 10% of combined sample	-0.0011**	-0.0011
	(2.10)	(1.24)
Delinquency score in top 10% of combined sample	-0.0099***	-0.0139***
	(8.16)	(7.55)
Total number of trades with balance > 0	0.0005***	0.0005***
	(8.45)	(4.71)
Total balance, non-mortgage trades (in 10,000s)	0.0003***	0.0005***
	(9.44)	(9.21)
Total balance, mortgages (in 10,000s)	-0.0000*	0.0001***
	(1.73)	(3.80)
Number of bankcard trades	0.0002***	0.0005***
	(5.97)	(8.05)
Proportion of bankcard trades with balance over 50% of limit	0.0045***	0.0064***
	(7.20)	(6.23)
Number of non-inst trades over 50 % of limit	0.0005***	0.0008***
	(5.41)	(4.84)
Number of trades 30 or more days past due in last 18 mths	-0.0001**	0.0001
	(2.09)	(0.51)
Number of currently past due balances	0.0013***	0.0022***
	(10.82)	(9.71)
Number of inquiries in last 6 months	0.0007***	0.0012***
	(12.06)	(12.40)
Highest retail credit limit (in 1,000s)	0.0004***	0.0006***
	(5.12)	(4.62)
Number of Observations	301492	276865

Samples are resticted to clients that had no record of a public bankruptcy filing in 2003 (column 1) or no record of a public derogatory event (column 2). The proportion of individuals who subsequently had a record of a public bankruptcy filing is .042 and the proportion of individuals who subsequently had a record of a public derogatory event is .063.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 20: Predicting Subsequent Delinquency and Bankruptcy Risk Scores Based on Credit Bureau Data and Counseling Event (OLS Model)

	Subsequent Delinquency Risk Score: Sample with initial no public derogatory in 2003	*Delinquency Risk Score: Full Sample*	*Subsequent Bankruptcy Risk Score: Sample with initial no public derogatory in 2003*	*Bankruptcy Risk Score: Full Sample*
Counseling group indicator	-0.1674***	-0.1557***	-0.5502***	-0.4426***
	(45.85)	(48.37)	(56.53)	(52.07)
Bankruptcy risk score (in 100s)	0.0428***	0.0444***	0.5776***	0.5957***
	(50.99)	(59.66)	(258.10)	(303.03)
Bankruptcy score in bottom 10% of combined sample	0.0425***	0.0452***	0.0819***	0.0052
	(8.01)	(10.97)	(5.79)	(0.48)
Bankruptcy score in top 10% of combined sample	-0.0201***	-0.0221***	0.2388***	0.2059***
	(4.91)	(5.50)	(21.88)	(19.42)
Delinquency risk score (in 100s)	0.8076***	0.8072***	0.5747***	0.5810***
	(395.93)	(424.57)	(105.66)	(115.75)
Delinquency score in bottom 10% of combined sample	0.0366***	0.0488***	-0.0230	0.0767***
	(6.68)	(10.86)	(1.57)	(6.47)
Delinquency score in top 10% of combined sample	-0.0136***	-0.0140***	-0.1590***	-0.1630***
	(3.35)	(3.48)	(14.63)	(15.31)
Total number of trades with balance > 0	0.0042***	0.0042***	-0.0452***	-0.0405***
	(7.58)	(7.95)	(30.37)	(29.18)
Total balance, non-mortgage trades (in 10,000s)	0.0043***	0.0040***	0.0070***	0.0072***
	(14.51)	(14.35)	(8.81)	(9.73)
Total balance, mortgages (in 10,000s)	0.0021***	0.0022***	0.0028***	0.0032***
	(17.39)	(18.82)	(8.51)	(10.52)
Number of bankcard trades	0.0066***	0.0072***	-0.0120***	-0.0151***
	(23.85)	(27.82)	(16.22)	(22.02)
Proportion of bankcard trades with balance over 50% of limit	-0.0333***	-0.0333***	-0.2337***	-0.2173***
	(6.82)	(7.48)	(17.92)	(18.50)
Number of non-inst trades over 50 % of limit	-0.0238***	-0.0247***	-0.0341***	-0.0303***
	(24.33)	(27.32)	(13.07)	(12.67)
Number of trades 30 or more days past due in last 18 mths	-0.0019**	-0.0021***	0.0133***	0.0065***
	(2.18)	(2.90)	(5.81)	(3.38)
Number of currently past due balances	0.0014	0.0052***	0.0484***	0.0618***
	(0.82)	(3.60)	(10.91)	(16.24)
Number of inquiries in last 6 months	-0.0059***	-0.0065***	-0.0102***	-0.0084***
	(9.62)	(12.02)	(6.18)	(5.91)
Highest retail credit limit (in 1,000s)	0.0076***	0.0081***	0.0129***	0.0143***
	(14.33)	(15.64)	(9.13)	(10.45)
Constant	1.1455***	1.1307***	-1.4133***	-1.6092***
	(83.70)	(90.83)	(38.73)	(48.96)
Number of Observations	276865	323887	276865	323887

Samples in columns 1 and 3 are restricted, respectively, to clients that had no record of a public bankruptcy filing in 2003 or no record of a public derogatory event. Samples in columns 2 and 4 are for the full sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Section IV: Predictors of Choice of Delivery Channel

Keeping in mind that the credit bureau information available around the time of counseling has yet to reflect the financial problems experienced by many clients, this section examines whether such observable variables are associated with counseled clients' choice of delivery channel. To perform this analysis, we consider a sample restricted to the five agencies that, according to Table 2, provided reasonably large samples of individuals counseled both by telephone and in person. These agencies were A, C, D, G, and H.

Table 21 reports the results of a Probit analysis for these agencies, restricting our analysis to individuals who used either telephone or face-to-face. These results indicate that individuals seeking with the highest bankruptcy and/or delinquency scores tend to be less likely to seek face-to-face counseling. Also, individuals with delinquency risk scores in the bottom decile of the sample are more likely than others to use face-to-face counseling. With regard to other credit bureau variables, individuals with more accounts with positive balances, larger mortgage balances, but fewer bank cards and less unsecured debt are more likely to seek face-to-face counseling. Finally, counselors involved in face-to-face services tend to be more experienced.

Table 21: Determinants of Face-to-Face Counseling Channel; Alternative is Telephone (Probit Model)

	Base specification with only bureau variables	*Include additional variables obtained during counseling*
Bankruptcy risk score (in 100s)	-0.0055**	-0.0059**
	(2.16)	(2.26)
Bankruptcy score in bottom 10% of combined sample	0.0097	0.0077
	(1.11)	(0.86)
Bankruptcy score in top 10% of combined sample	-0.1346***	-0.1565***
	(3.18)	(3.83)
Delinquency risk score (in 100s)	-0.0059	-0.0003
	(0.92)	(0.05)
Delinquency score in bottom 10% of combined sample	0.0461***	0.0363***
	(3.98)	(3.07)
Delinquency score in top 10% of combined sample	-0.0985**	-0.1162***
	(2.37)	(2.88)
Total number of trades with balance > 0	0.0075***	0.0059***
	(5.25)	(4.05)
Total balance, non-mortgage trades (in 10,000s)	-0.0011	0.0015
	(0.99)	(1.31)
Total balance, mortgages (in 10,000s)	0.0003	0.0013***
	(0.62)	(2.58)
Number of bankcard trades	-0.0056***	-0.0039***
	(6.61)	(4.52)
Proportion of bankcard trades with balance over 50% of limit	-0.0274**	-0.0089
	(2.04)	(0.65)
Number of non-inst trades over 50 % of limit	0.0022	0.0016
	(1.06)	(0.76)
Number of trades 30 or more days past due in last 18 mths	0.0005	0.0003
	(0.35)	(0.21)
Number of currently past due balances	0.0016	0.0009
	(0.66)	(0.35)
Number of inquiries in last 6 months	0.0018	0.0015
	(1.44)	(1.14)
Highest retail credit limit (in 1,000s)	-0.0015	-0.0011
	(0.86)	(0.62)
Counseling Interview: Number of unsecured creditors		0.0030***
		(3.89)
Counseling interview: Total unsecured debt in $1,000		-0.0011***
		(8.63)
Log of counselor experience (in months)		0.2061***
		(42.83)
Number of Observations	29537	29537

Analysis restricted to five agencies that offer significant counseling services by phone and in person. Excluded from our analysis are individuals counseled using the internet. Not reported are variables indicating missing values for data obtained during the counseling session as well as agency-identifier variables. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample. Dummy variables indicating the agency were included.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Section V: Counseling Delivery Methods and Outcomes

This section provides various tests of the effect of counseling channel on the clients' credit profile two years later. Because Internet counseling was not consistently defined across agencies in 2003 (e.g., some offered online intake of client financial information but did not classify that as Internet counseling) we limit the analysis to individuals who had an initial counseling session either over the phone or in person. We also restrict the sample to individuals who had no record of bankruptcy filing in their credit report at the time of counseling.

For this group, there are two potential samples to consider. One sample includes all agencies, including those that specialize in one type of delivery or the other. Most consumers have a meaningful choice of delivery options because they have two or more counseling agencies from which to choose. It is possible that consumers express a preference for a delivery channel by their selection of a counseling agency that specializes predominantly in telephone counseling (3 agencies in our sample) or in face-to-face counseling (2 agencies). However, while telephone counseling is available and advertised nearly everywhere in the U.S., not all communities have face-to-face counseling options locally or within a short driving distance. Consequently, we utilize a second sample that includes only the five agencies that offered clients a choice of delivery channel and a significant proportion of clients enrolled in each channel. By focusing on these five agencies, we reduce the concern of sample bias due to selection of an agency based on its specialization in a specific delivery channel, and the consumer's preference for that channel

Tables 22 through 24 display the results of Probit models that predict, respectively, the incidence of bankruptcy during the two years following counseling; the client's bankruptcy risk score measured at a point two years after counseling, and the clients' delinquency risk score measured at a point two years after counseling. Together these provide three distinct measures of post-counseling credit experience. For each of these tables, we report an "A" version that utilizes the full sample of agencies and a "B" version that is restricted to the five agencies that offered clients a choice of delivery channel and had a significant percent of their clients in either channel.

To identify potential determinants of bankruptcy filings, Table 22 reports Probit model estimation results under various specifications. The first column in Table 21 (A and B) adopts a specification that relies only on credit bureau variables, including risk scores. This provides a base-line result. The second column adds a variable to indicate if the counseling was done in person. The third column adds additional variables captured during the counseling interview, including the number of unsecured creditors, size of unsecured debt, and experience of the counselor, in months (log form).

Focusing on the third column of Table 22A, note that many of the variables are significant in the expected direction (e.g., higher bankruptcy risk score in 2003 is associated with lower bankruptcy incidence after counseling). As for the impact of the counseling delivery channel, note that among individuals who otherwise appear identical in terms of credit bureau variables (i.e., controlling for credit bureau characteristics), the client who experiences an in-person counseling session is more likely to file for bankruptcy during the two years following the initial counseling session. Also note that an increase in the counselor's experience does reduce the subsequent likelihood of a bankruptcy filing.

Tables 23A and 23B consider the same variable specifications as Table 22A and 22B, but adopt as the dependent variable the individual's bankruptcy risk score in 2005, as opposed to the actual bankruptcy incidence between 2003 and 2005 that is modeled in Table 22. In other words, Tables 23A and 23B model the impact of the included variables on one measure of the client's future creditworthiness, namely the client's risk of future bankruptcy at a point two years out from counseling as indicated by their bankruptcy risk score at that time. Table 24A and 24B are similar to Tables 23A and 23B, but use the client's delinquency risk score in 2005 as the dependent variable.

For the full specification (third column) in Tables 23A and 24A, the effect of "face-to-face" counseling sessions is not statistically significant with respect to the subsequent bankruptcy risk score, but in-person counseling sessions do appear to be associated with a higher subsequent delinquency risk score.[3] As noted earlier, these results for the full sample of ten agencies are similar to ones obtained when the sample is restricted to agencies that offered significant levels of both types of counseling (compare Tables 23A and 24A to Tables 23B and 24B, respectively).

[3] The latter result is significant only at the 10% level.

Table 22A: Effect of Counseling Channel (Telephone versus In Person) on the Likelihood of Bankruptcy During Two Years Following Counseling Event (Probit Model)

	Full Sample (Ten Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	-0.0239***	-0.0239***	-0.0230***
	(15.57)	(15.56)	(14.98)
Bankruptcy score in bottom 10% of combined sample	-0.0192***	-0.0193***	-0.0192***
	(3.93)	(3.94)	(3.91)
Bankruptcy score in top 10% of combined sample	-0.1196***	-0.1188**	-0.1182**
	(2.60)	(2.56)	(2.56)
Delinquency risk score (in 100s)	0.0368***	0.0368***	0.0341***
	(10.09)	(10.09)	(9.28)
Delinquency score in bottom 10% of combined sample	0.0211***	0.0207***	0.0169**
	(3.00)	(2.94)	(2.41)
Delinquency score in top 10% of combined sample	-0.1112***	-0.1107***	-0.1064***
	(3.33)	(3.30)	(3.13)
Total number of trades with balance > 0	0.0042***	0.0042***	0.0043***
	(5.54)	(5.48)	(5.55)
Total balance, non-mortgage trades (in 10,000s)	0.0058***	0.0058***	0.0049***
	(10.83)	(10.84)	(8.97)
Total balance, mortgages (in 10,000s)	0.0001	0.0001	-0.0004
	(0.57)	(0.56)	(1.45)
Number of bankcard trades	0.0008*	0.0009*	0.0003
	(1.85)	(1.94)	(0.73)
Proportion of bankcard trades with balance over 50% of limit	0.0041	0.0043	0.0017
	(0.53)	(0.56)	(0.23)
Number of non-inst trades over 50 % of limit	0.0042***	0.0042***	0.0033***
	(3.98)	(3.96)	(3.07)
Number of trades 30 or more days past due in last 18 mths	-0.0039***	-0.0039***	-0.0041***
	(4.87)	(4.88)	(5.11)
Number of currently past due balances	0.0131***	0.0131***	0.0128***
	(9.79)	(9.78)	(9.61)
Number of inquiries in last 6 months	0.0073***	0.0073***	0.0073***
	(11.52)	(11.51)	(11.59)
Highest retail credit limit (in 1,000s)	0.0031***	0.0031***	0.0025***
	(3.33)	(3.34)	(2.70)
Counseling in person (alternative is telephone)		0.0131**	0.0176***
		(2.54)	(3.28)
Counseling Interview: Number of unsecured creditors			0.0019***
			(3.77)
Counseling interview: Total unsecured debt in $1,000			0.0006***
			(8.26)
Log of counselor experience (in months)			-0.0044*
			(1.71)
Number of Observations	49046	49046	49046

Excluded from our analysis are individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 22B: Effect of Counseling Channel (Telephone versus In Person) on the Likelihood of Bankruptcy During Two Years Following Counseling Event - Restriced Set of Agencies (Probit Model)

	Restricted Sample (Five Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	-0.0246***	-0.0246***	-0.0239***
	(12.18)	(12.16)	(11.82)
Bankruptcy score in bottom 10% of combined sample	-0.0130**	-0.0131**	-0.0128*
	(1.99)	(2.01)	(1.96)
Bankruptcy score in top 10% of combined sample	-0.1311**	-0.1303**	-0.1294**
	(2.30)	(2.27)	(2.26)
Delinquency risk score (in 100s)	0.0412***	0.0411***	0.0403***
	(8.50)	(8.50)	(8.28)
Delinquency score in bottom 10% of combined sample	0.0266***	0.0258***	0.0223**
	(2.82)	(2.74)	(2.37)
Delinquency score in top 10% of combined sample	-0.1235***	-0.1229***	-0.1209***
	(3.06)	(3.04)	(2.97)
Total number of trades with balance > 0	0.0032***	0.0031***	0.0028***
	(3.18)	(3.10)	(2.78)
Total balance, non-mortgage trades (in 10,000s)	0.0068***	0.0068***	0.0062***
	(9.67)	(9.68)	(8.59)
Total balance, mortgages (in 10,000s)	-0.0001	-0.0002	-0.0005
	(0.45)	(0.47)	(1.54)
Number of bankcard trades	0.0001	0.0002	-0.0003
	(0.17)	(0.29)	(0.54)
Proportion of bankcard trades with balance over 50% of limit	0.0148	0.0153	0.0138
	(1.46)	(1.51)	(1.36)
Number of non-inst trades over 50 % of limit	0.0058***	0.0058***	0.0045***
	(4.07)	(4.04)	(3.09)
Number of trades 30 or more days past due in last 18 mths	-0.0029***	-0.0029***	-0.0033***
	(2.68)	(2.70)	(3.05)
Number of currently past due balances	0.0111***	0.0110***	0.0108***
	(6.24)	(6.23)	(6.13)
Number of inquiries in last 6 months	0.0069***	0.0069***	0.0070***
	(7.78)	(7.76)	(7.86)
Highest retail credit limit (in 1,000s)	0.0023*	0.0023*	0.0019
	(1.93)	(1.94)	(1.54)
Counseling in person (alternative is telephone)		0.0130**	0.0172***
		(2.54)	(3.22)
Counseling Interview: Number of unsecured creditors			0.0026***
			(4.71)
Counseling interview: Total unsecured debt in $1,000			0.0003***
			(4.53)
Log of counselor experience (in months)			-0.0048*
			(1.71)
Number of Observations	27047	27047	27047

The analysis is restricted to the five agencies that offer significant counseling services by phone and in person. Excluded from our analysis are individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 23A: Effect of Counseling Channel (Telephone versus In Person) on Bureau Bankruptcy Risk Score Two Years Following Counseling Event (Ordinary Least Squares)

	Full Sample (Ten Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	0.3637***	0.3637***	0.3610***
	(55.11)	(55.11)	(54.67)
Bankruptcy score in bottom 10% of combined sample	-0.0783***	-0.0783***	-0.0806***
	(3.35)	(3.35)	(3.45)
Bankruptcy score in top 10% of combined sample	1.2693***	1.2697***	1.2481***
	(9.50)	(9.50)	(9.35)
Delinquency risk score (in 100s)	0.4733***	0.4733***	0.4721***
	(28.30)	(28.30)	(28.06)
Delinquency score in bottom 10% of combined sample	-0.0430	-0.0431	-0.0290
	(1.40)	(1.41)	(0.95)
Delinquency score in top 10% of combined sample	0.7682***	0.7686***	0.7402***
	(5.96)	(5.96)	(5.74)
Total number of trades with balance > 0	-0.0045	-0.0045	-0.0021
	(1.21)	(1.22)	(0.56)
Total balance, non-mortgage trades (in 10,000s)	0.0052*	0.0052*	0.0059**
	(1.88)	(1.88)	(2.10)
Total balance, mortgages (in 10,000s)	0.0068***	0.0068***	0.0074***
	(5.35)	(5.35)	(5.69)
Number of bankcard trades	-0.0166***	-0.0166***	-0.0154***
	(7.53)	(7.53)	(6.93)
Proportion of bankcard trades with balance over 50% of limi	-0.1190***	-0.1189***	-0.1137***
	(3.41)	(3.41)	(3.26)
Number of non-inst trades over 50 % of limit	-0.0800***	-0.0800***	-0.0743***
	(15.38)	(15.39)	(14.23)
Number of trades 30 or more days past due in last 18 mths	0.0263***	0.0263***	0.0281***
	(6.95)	(6.95)	(7.44)
Number of currently past due balances	-0.0183***	-0.0183***	-0.0181***
	(2.83)	(2.83)	(2.80)
Number of inquiries in last 6 months	-0.0170***	-0.0170***	-0.0173***
	(5.42)	(5.42)	(5.52)
Highest retail credit limit (in 1,000s)	0.0070	0.0070	0.0081*
	(1.54)	(1.54)	(1.79)
Counseling in person (alternative is telephone)		0.0034	-0.0086
		(0.15)	(0.36)
Counseling Interview: Number of unsecured creditors			-0.0216***
			(8.80)
Counseling interview: Total unsecured debt in $1,000			-0.0007*
			(1.84)
Log of counselor experience (in months)			0.0086
			(0.73)
Number of Observations	49046	49046	49046

We exclude from our analysis individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 23B: Effect of Counseling Channel (Telephone versus In Person) on Bureau Bankruptcy Risk Score Two Years Following Counseling Event - Restriced Set of Agencies (Ordinary Least Squares)

	Restricted Sample (Five Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	0.3777***	0.3777***	0.3740***
	(42.26)	(42.26)	(41.85)
Bankruptcy score in bottom 10% of combined sample	-0.1207***	-0.1207***	-0.1245***
	(3.74)	(3.74)	(3.87)
Bankruptcy score in top 10% of combined sample	1.3850***	1.3858***	1.3670***
	(9.09)	(9.09)	(8.98)
Delinquency risk score (in 100s)	0.4832***	0.4832***	0.4777***
	(21.22)	(21.22)	(20.90)
Delinquency score in bottom 10% of combined sample	-0.0467	-0.0469	-0.0298
	(1.11)	(1.11)	(0.71)
Delinquency score in top 10% of combined sample	0.5488***	0.5494***	0.5339***
	(3.71)	(3.71)	(3.61)
Total number of trades with balance > 0	-0.0055	-0.0055	-0.0013
	(1.10)	(1.10)	(0.26)
Total balance, non-mortgage trades (in 10,000s)	0.0016	0.0016	-0.0014
	(0.44)	(0.44)	(0.38)
Total balance, mortgages (in 10,000s)	0.0061***	0.0061***	0.0064***
	(3.61)	(3.61)	(3.71)
Number of bankcard trades	-0.0131***	-0.0131***	-0.0115***
	(4.38)	(4.37)	(3.82)
Proportion of bankcard trades with balance over 50% of limi	-0.2048***	-0.2046***	-0.1987***
	(4.34)	(4.34)	(4.21)
Number of non-inst trades over 50 % of limit	-0.0817***	-0.0817***	-0.0729***
	(11.35)	(11.36)	(10.06)
Number of trades 30 or more days past due in last 18 mths	0.0246***	0.0246***	0.0279***
	(4.73)	(4.72)	(5.36)
Number of currently past due balances	-0.0114	-0.0114	-0.0114
	(1.28)	(1.28)	(1.28)
Number of inquiries in last 6 months	-0.0137***	-0.0137***	-0.0143***
	(3.00)	(3.00)	(3.14)
Highest retail credit limit (in 1,000s)	0.0042	0.0042	0.0055
	(0.70)	(0.70)	(0.91)
Counseling in person (alternative is telephone)		0.0052	-0.0150
		(0.21)	(0.59)
Counseling Interview: Number of unsecured creditors			-0.0220***
			(7.80)
Counseling interview: Total unsecured debt in $1,000			-0.0003
			(0.83)
Log of counselor experience (in months)			0.0108
			(0.82)
Number of Observations	27047	27047	27047

The analysis is restricted to the five agencies that offer significant counseling services by phone and in person. Excluded from our analysis are individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 24A: Effect of Counseling Channel (Telephone versus In Person) on Bureau Delinquency Risk Score Two Years Following Counseling Event (Ordinary Least Squares)

	Full Sample (Ten Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	0.0422***	0.0422***	0.0423***
	(15.32)	(15.33)	(15.33)
Bankruptcy score in bottom 10% of combined sample	0.0180*	0.0181*	0.0167*
	(1.85)	(1.85)	(1.72)
Bankruptcy score in top 10% of combined sample	0.3249***	0.3274***	0.3241***
	(5.83)	(5.87)	(5.81)
Delinquency risk score (in 100s)	0.6129***	0.6130***	0.6080***
	(87.76)	(87.77)	(86.51)
Delinquency score in bottom 10% of combined sample	-0.0241*	-0.0246*	-0.0207
	(1.89)	(1.92)	(1.62)
Delinquency score in top 10% of combined sample	0.2209***	0.2228***	0.2235***
	(4.10)	(4.14)	(4.15)
Total number of trades with balance > 0	0.0005	0.0004	0.0018
	(0.30)	(0.26)	(1.18)
Total balance, non-mortgage trades (in 10,000s)	0.0128***	0.0128***	0.0116***
	(11.13)	(11.14)	(9.91)
Total balance, mortgages (in 10,000s)	0.0045***	0.0045***	0.0042***
	(8.52)	(8.52)	(7.73)
Number of bankcard trades	0.0158***	0.0159***	0.0156***
	(17.16)	(17.21)	(16.75)
Proportion of bankcard trades with balance over 50% of limi	0.0706***	0.0709***	0.0677***
	(4.85)	(4.87)	(4.64)
Number of non-inst trades over 50 % of limit	-0.0243***	-0.0243***	-0.0230***
	(11.20)	(11.21)	(10.52)
Number of trades 30 or more days past due in last 18 mths	0.0057***	0.0057***	0.0064***
	(3.63)	(3.63)	(4.07)
Number of currently past due balances	-0.0208***	-0.0208***	-0.0209***
	(7.69)	(7.70)	(7.74)
Number of inquiries in last 6 months	-0.0128***	-0.0128***	-0.0128***
	(9.82)	(9.82)	(9.81)
Highest retail credit limit (in 1,000s)	0.0168***	0.0168***	0.0164***
	(8.85)	(8.85)	(8.59)
Counseling in person (alternative is telephone)		0.0175*	0.0212**
		(1.79)	(2.08)
Counseling Interview: Number of unsecured creditors			-0.0088***
			(8.57)
Counseling interview: Total unsecured debt in $1,000			0.0007***
			(4.35)
Log of counselor experience (in months)			-0.0027
			(0.56)
Number of Observations	49046	49046	49046

We exclude from our analysis individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 24B: Effect of Counseling Channel (Telephone versus In Person) on Bureau Delinquency Risk Score Two Years Following Counseling Event - Restricted Set of Agencies (Ordinary Least Squares)

	Restricted Sample (Five Agencies)		
	Base specification: only bureau variables	*Include variable indicating counseling delivery channel was in person*	*Include additional variables obtained during counseling session*
Bankruptcy risk score (in 100s)	0.0468***	0.0468***	0.0463***
	(12.81)	(12.83)	(12.69)
Bankruptcy score in bottom 10% of combined sample	0.0138	0.0139	0.0122
	(1.05)	(1.05)	(0.93)
Bankruptcy score in top 10% of combined sample	0.3519***	0.3543***	0.3536***
	(5.65)	(5.69)	(5.68)
Delinquency risk score (in 100s)	0.6102***	0.6103***	0.6054***
	(65.61)	(65.62)	(64.79)
Delinquency score in bottom 10% of combined sample	-0.0345**	-0.0353**	-0.0284*
	(2.01)	(2.06)	(1.65)
Delinquency score in top 10% of combined sample	0.2096***	0.2114***	0.2150***
	(3.47)	(3.50)	(3.56)
Total number of trades with balance > 0	0.0005	0.0004	0.0024
	(0.26)	(0.20)	(1.15)
Total balance, non-mortgage trades (in 10,000s)	0.0125***	0.0125***	0.0113***
	(8.19)	(8.20)	(7.23)
Total balance, mortgages (in 10,000s)	0.0042***	0.0042***	0.0038***
	(6.10)	(6.10)	(5.39)
Number of bankcard trades	0.0163***	0.0164***	0.0164***
	(13.37)	(13.42)	(13.39)
Proportion of bankcard trades with balance over 50% of limi	0.0304	0.0309	0.0278
	(1.58)	(1.60)	(1.44)
Number of non-inst trades over 50 % of limit	-0.0242***	-0.0243***	-0.0213***
	(8.25)	(8.27)	(7.18)
Number of trades 30 or more days past due in last 18 mths	0.0047**	0.0047**	0.0059***
	(2.22)	(2.21)	(2.78)
Number of currently past due balances	-0.0193***	-0.0193***	-0.0194***
	(5.30)	(5.31)	(5.34)
Number of inquiries in last 6 months	-0.0102***	-0.0102***	-0.0103***
	(5.48)	(5.49)	(5.52)
Highest retail credit limit (in 1,000s)	0.0134***	0.0135***	0.0133***
	(5.46)	(5.47)	(5.42)
Counseling in person (alternative is telephone)		0.0173*	0.0192*
		(1.74)	(1.85)
Counseling Interview: Number of unsecured creditors			-0.0090***
			(7.83)
Counseling interview: Total unsecured debt in $1,000			0.0005***
			(2.76)
Log of counselor experience (in months)			-0.0038
			(0.70)
Number of Observations	27047	27047	27047

The analysis is restricted to the five agencies that offer significant counseling services by phone and in person. Excluded from our analysis are individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients indicate marginal effects; * significant at 10%; ** significant at 5%, *** significant at 1%

1. The predictive value of the counselor's recommendation

The previous models assume that risk scores and other credit bureau information, supplemented with counseling interview data, are sufficient to identify factors other than counseling that could affect subsequent bankruptcy experience and future risk scores. However, we have additional information on the financial situation of the individual seeking counseling that can be summarized by the counselor's outcome recommendation. Insights gained through the counseling interview presumably convey at least some of the client's private information about financial circumstances that is not otherwise observable through credit report data. Presumably, that information would influence the counselor's recommended plan of action.

To see if such information is important, Table 25 adds to the specification in Tables 22A, 23A, and 24A (third columns) "evaluation" variables that indicate the recommendation of the counselor. The counselor can recommend a debt management plan (DMP), financial counseling/referral, or that the individual can self-manage the situation. Cases in the excluded recommendation category are those for which a recommendation was missing in the database, sometimes due to an incomplete session. We also include two additional variables indicating whether a DMP was actually started. One variable identifies cases where a DMP was recommended and started, and the second variable identified cases in which a DMP was not recommended, but was started anyway (perhaps as a result of a change in the client's situation).

The counselor's recommendation does indeed convey information not otherwise observable through the credit report variables. Perhaps not surprisingly, individuals who are considered capable of self-management fare best in terms of the lowest incidence of a bankruptcy filing and the highest risk scores (both bankruptcy and delinquency risk scores) by 2005. Interestingly, clients for whom the counselor recommends a DMP, and who actually start payments on a plan, have a significantly lower incidence of bankruptcy and higher risk scores two years later. Those who fare worst are individuals who are referred to other agencies or services (including legal services), consistent with the identification of problems sufficiently serious to need other assistance.

Controlling for the different circumstances of individuals as reflected in different counselor recommendations, it remains the case that face-to-face clients have, at best, no statistically significant difference in outcome from telephone clients (delinquency risk score in 2005), and in terms of bankruptcy incidence and subsequent bankruptcy risk, in-person clients fare worse than those who received telephone counseling. Additional specifications that also included geographic controls (namely, variables indicating the state of residence of the individual) provide the same results.

Some exploratory analysis was conducted to consider separately each of the five agencies that offered substantial counseling both by telephone and in person. This analysis is confidential, for the agencies are not pooled. The analysis indicates that the result that clients counseled in-person were more likely to declare bankruptcy during the subsequent two years was found in three of the five agencies. For the remaining two agencies, there was no significant difference in the bankruptcy incidence for clients counseled in person vs. by telephone. Interestingly, for

three of the five agencies, having a client start payments on a DMP significantly reduced the incidence of bankruptcy over the subsequent two years. It appears that the role of DMPs in improving clients' post-counseling credit profile and experience is worth exploring in greater detail in the next phase of this project.

2. Alternative measures of client performance after counseling

Table 26 considers two additional measures of client performance two years after counseling, namely, total dollar balances for non-mortgage debt and the number of trades (accounts) that were 30 or more days delinquent during the previous 18 months, both measured as of 2005. Table 26 also includes the estimates for bankruptcy incidence during the two years following counseling, for comparative purposes. Total non-mortgage balances do not seem to be affected by the counseling delivery channel. However, individuals who experience face-to-face counseling do better in terms of a reduced number of recent delinquencies two years later

Table 25: Effects of Counseling Channel (Telephone versus In Person) on Performance Controlling for Counselor Recommendation

	Effect on likelihood of bankruptcy filing over next two years (Probit model)	*Effect on Bureau bankruptcy risk score two years later (OLS model)*	*Effect on Bureau delinquency risk score two years later (OLS model)*
Bankruptcy risk score (in 100s)	-0.0222***	0.3583***	0.0417***
	(14.57)	(54.38)	(15.18)
Bankruptcy score in bottom 10% of combined sample	-0.0198***	-0.0790***	0.0177*
	(4.09)	(3.39)	(1.83)
Bankruptcy score in top 10% of combined sample	-0.1210***	1.2611***	0.3372***
	(2.66)	(9.47)	(6.07)
Delinquency risk score (in 100s)	0.0314***	0.4762***	0.6092***
	(8.61)	(28.37)	(87.03)
Delinquency score in bottom 10% of combined sample	0.0044	-0.0056	-0.0013
	(0.65)	(0.18)	(0.10)
Delinquency score in top 10% of combined sample	-0.1070***	0.7529***	0.2357***
	(3.24)	(5.86)	(4.40)
Total number of trades with balance > 0	0.0045***	-0.0029	0.0017
	(5.99)	(0.79)	(1.10)
Total balance, non-mortgage trades (in 10,000s)	0.0046***	0.0067**	0.0120***
	(8.38)	(2.41)	(10.29)
Total balance, mortgages (in 10,000s)	-0.0003	0.0072***	0.0043***
	(1.25)	(5.60)	(7.91)
Number of bankcard trades	-0.0003	-0.0140***	0.0164***
	(0.73)	(6.31)	(17.66)
Proportion of bankcard trades with balance over 50% of limit	0.0085	-0.1246***	0.0584***
	(1.11)	(3.58)	(4.02)
Number of non-inst trades over 50 % of limit	0.0035***	-0.0750***	-0.0239***
	(3.28)	(14.39)	(11.01)
Number of trades 30 or more days past due in last 18 mths	-0.0031***	0.0259***	0.0049***
	(3.86)	(6.85)	(3.08)
Number of currently past due balances	0.0110***	-0.0139**	-0.0190***
	(8.28)	(2.16)	(7.05)
Number of inquiries in last 6 months	0.0063***	-0.0152***	-0.0112***
	(10.08)	(4.86)	(8.60)
Highest retail credit limit (in 1,000s)	0.0018*	0.0097**	0.0170***
	(1.95)	(2.14)	(8.99)
Counseling in person (alternative is telephone)	0.0238***	-0.0315	0.0052
	(4.41)	(1.29)	(0.51)
Counseling Interview: Number of unsecured creditors	0.0034***	-0.0235***	-0.0106***
	(6.73)	(9.53)	(10.31)
Counseling interview: Total unsecured debt in $1,000	0.0004***	-0.0003	0.0009***
	(5.65)	(0.73)	(5.90)
Log of counselor experience (in months)	-0.0018	0.0020	-0.0055
	(0.70)	(0.17)	(1.12)
Evaluation: Self-manage/Client can handle	-0.0100	0.0711	0.0165
	(0.87)	(1.32)	(0.73)
Evaluation: DMP recommended by counselor	0.0033	-0.1460***	-0.0496***
	(0.34)	(3.26)	(2.66)
DMP payments started with recommendation	-0.0797***	0.2115***	0.1628***
	(18.63)	(10.17)	(18.76)
DMP payments started without recommendation	-0.0750***	0.0614	0.0678**
	(5.83)	(0.90)	(2.38)
Evaluation: Financial counseling only	0.0313**	-0.1604***	-0.0494**
	(2.55)	(2.98)	(2.20)
Evaluation: Referral to other agencies	0.0155	-0.1065**	-0.0274
	(1.46)	(2.22)	(1.37)
Evaluation: Referral to legal assistance/advice	0.2021***	-0.6107***	-0.1309***
	(12.87)	(9.97)	(5.12)
Number of Observations	49046	49046	49046

The analysis includes all ten agencies. Excluded from the analysis are individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients for Probit indicate marginal effects; * significant at 10%, ** significant at 5%; *** significant at 1%

Table 26: Effects of Counseling Channel (Telephone versus In Person) on Alternative Performance Measures Controlling for Counselor Recommendation

	Effect on likelihood of bankruptcy filing over next two years (Probit model)	*Effect on Total Non-Mortgage Balances two years later (OLS model)*	*Effect on Number of Trades 30+ delinquent Over Prior 18 Months two years later (OLS model)*
Bankruptcy risk score (in 100s)	-0.0222***	0.0972***	-0.0579***
	(14.57)	(10.38)	(5.50)
Bankruptcy score in bottom 10% of combined sample	-0.0198***	-0.0324	-0.1835***
	(4.09)	(0.98)	(4.92)
Bankruptcy score in top 10% of combined sample	-0.1210***	-0.1384	0.3294
	(2.66)	(0.73)	(1.55)
Delinquency risk score (in 100s)	0.0314***	-0.0499**	-0.5026***
	(8.61)	(2.09)	(18.71)
Delinquency score in bottom 10% of combined sample	0.0044	0.0370	-1.0287***
	(0.65)	(0.85)	(20.98)
Delinquency score in top 10% of combined sample	-0.1070***	-0.2442	0.3242
	(3.24)	(1.34)	(1.58)
Total number of trades with balance > 0	0.0045***	0.1646***	0.2204***
	(5.99)	(31.38)	(37.34)
Total balance, non-mortgage trades (in 10,000s)	0.0046***	0.3779***	-0.0080*
	(8.38)	(94.84)	(1.79)
Total balance, mortgages (in 10,000s)	-0.0003	0.0220***	0.0150***
	(1.25)	(11.97)	(7.23)
Number of bankcard trades	-0.0003	0.0049	-0.0123***
	(0.73)	(1.54)	(3.47)
Proportion of bankcard trades with balance over 50% of limit	0.0085	0.3587***	-0.1102**
	(1.11)	(7.24)	(1.98)
Number of non-inst trades over 50 % of limit	0.0035***	-0.2096***	0.0848***
	(3.28)	(28.30)	(10.17)
Number of trades 30 or more days past due in last 18 mths	-0.0031***	0.0230***	0.1732***
	(3.86)	(4.28)	(28.66)
Number of currently past due balances	0.0110***	-0.1036***	0.0164
	(8.28)	(11.29)	(1.59)
Number of inquiries in last 6 months	0.0063***	0.0033	0.0379***
	(10.08)	(0.75)	(7.57)
Highest retail credit limit (in 1,000s)	0.0018*	-0.0344***	-0.0179**
	(1.95)	(5.32)	(2.45)
Counseling in person (alternative is telephone)	0.0238***	-0.0343	-0.0909**
	(4.41)	(0.99)	(2.32)
Counseling Interview: Number of unsecured creditors	0.0034***	-0.0004	0.0272***
	(6.73)	(0.10)	(6.89)
Counseling interview: Total unsecured debt in $1,000	0.0004***	-0.0020***	-0.0033***
	(5.65)	(3.89)	(5.80)
Log of counselor experience (in months)	-0.0018	-0.0282*	-0.0060
	(0.70)	(1.70)	(0.32)
Evaluation: Self-manage/Client can handle	-0.0100	0.1101	0.0514
	(0.87)	(1.44)	(0.60)
Evaluation: DMP recommended by counselor	0.0033	0.0484	0.1926***
	(0.34)	(0.76)	(2.69)
DMP payments started with recommendation	-0.0797***	-0.0096	-0.2399***
	(18.63)	(0.33)	(7.21)
DMP payments started without recommendation	-0.0750***	-0.1424	-0.0482
	(5.83)	(1.47)	(0.44)
Evaluation: Financial counseling only	0.0313**	-0.0136	0.1654*
	(2.55)	(0.18)	(1.92)
Evaluation: Referral to other agencies	0.0155	-0.0765	0.1215
	(1.48)	(1.12)	(1.58)
Evaluation: Referral to legal assistance/advice	0.2021***	-0.6791***	-0.1844*
	(12.87)	(7.80)	(1.88)
Number of Observations	49046	49046	49046

We exclude from our analysis individuals counseled using the internet. Control variables for the individual agencies as well as variables indicating missing values for data obtained during the counseling session are included in the analysis but not reported. Only individuals who had no public record of bankruptcy filings in 2003 are included in the sample.

Coefficients for Probit indicate marginal effects; * significant at 10%; ** at 5%; *** at 1%

3. Predictive value of clients' primary cause of financial difficulty

During the counseling interview, a reason is typically identified as a prime source for the financial difficulties faced by the client. Such primary causes were listed in Tables 5 and 6. It may be that the subsequent performance of the individual is related to the cause. To see if this is the case, Table 27 displays estimates similar to Table 26 but with the inclusion of various "reasons."

In fact, the information collected during the counseling interview regarding primary cause of difficulty is predictive, especially after controlling for the full set of variables in the model. For example, income loss/instability raises the risk of bankruptcy during the next two years, even after controlling for the client's bankruptcy risk score (second column). It also lowers the client's bankruptcy and delinquency risk scores measured two years later (third and fourth columns).

Two key findings remain robust. First, in-person clients have a higher incidence of bankruptcy following counseling, and the delivery channel has no significant impact on either of the clients' risk scores measured two years out from counseling. Second, when a DMP is started, the client's likelihood of bankruptcy over the next two years falls, and client risk scores tend to be higher after two years.

To see if this gain to DMP counseling is related to the delivery channel, another specification of the model was estimated in which the DMP variable is interacted with a variable indicating that counseling was conducted in person. Table 28 presents the results. The results indicate no significant difference in the positive effect of engagement in a DMP across delivery channels.

Table 27: Effects of Recorded Reason for Counseling on Subsequent Performance (Compare to Table 26)

	Effect on likelihood of bankruptcy filing over next two years (Probit model)	*Effect on likelihood of bankruptcy filing over next two years (Probit model)*	*Effect on Bureau bankruptcy risk score two years later (OLS model)*	*Effect on Bureau delinquency risk score two years later (OLS model)*
Cause: income loss / instability	0.0059	0.0156**	-0.1779***	-0.0746***
	(0.92)	(2.34)	(5.76)	(5.80)
Cause: poor money management	-0.0053	-0.0015	-0.0470	-0.0133
	(0.83)	(0.23)	(1.51)	(1.03)
Cause: death / illness / disability	0.0071	0.0141*	-0.1604***	-0.0741***
	(0.87)	(1.70)	(4.19)	(4.64)
Cause: domestic issues	0.0115	0.0207**	-0.2462***	-0.1150***
	(1.17)	(2.07)	(5.40)	(6.05)
Cause: legal	-0.0241	-0.0129	0.0530	-0.0103
	(0.72)	(0.38)	(0.35)	(0.16)
Cause: expenses	0.0340	0.0465**	0.0942	-0.0022
	(1.47)	(1.99)	(0.92)	(0.05)
Cause: school expenses	-0.1106***	-0.0852***	0.1295	-0.0147
	(5.38)	(3.94)	(1.33)	(0.36)
Cause: substance abuse	0.0158	-0.0251	-0.0602	-0.1198
	(0.29)	(0.51)	(0.25)	(1.18)
Bankruptcy risk score (in 100s)		-0.0219***	0.3565***	0.0410***
		(14.36)	(54.11)	(14.92)
Bankruptcy score in bottom 10% of combined sample		-0.0192***	-0.0822***	0.0165*
		(3.95)	(3.53)	(1.70)
Bankruptcy score in top 10% of combined sample		-0.1212***	1.2333***	0.3262***
		(2.66)	(9.26)	(5.87)
Delinquency risk score (in 100s)		0.0314***	0.4746***	0.6082***
		(8.62)	(28.29)	(86.94)
Delinquency score in bottom 10% of combined sample		0.0045	-0.0083	-0.0024
		(0.66)	(0.27)	(0.19)
Delinquency score in top 10% of combined sample		-0.1067***	0.7314***	0.2266***
		(3.23)	(5.69)	(4.23)
Counseling in person (alternative is telephone)		0.0238***	-0.0311	0.0054
		(4.40)	(1.27)	(0.53)
Log of counselor experience (in months)		-0.0023	0.0051	-0.0041
		(0.89)	(0.44)	(0.84)
Evaluation: Self-manage/Client can handle		-0.0118	0.0979*	0.0290
		(1.01)	(1.80)	(1.28)
Evaluation: DMP recommended by counselor		0.0004	-0.0983**	-0.0294
		(0.04)	(2.12)	(1.52)
DMP payments started with recommendation		-0.0795***	0.2110***	0.1625***
		(18.60)	(10.14)	(18.74)
DMP payments started without recommendation		-0.0742***	0.0671	0.0694**
		(5.77)	(0.98)	(2.44)
Evaluation: Financial counseling only		0.0283**	-0.1180**	-0.0312
		(2.27)	(2.16)	(1.37)
Evaluation: Referral to other agencies		0.0131	-0.0715	-0.0124
		(1.22)	(1.47)	(0.61)
Evaluation: Referral to legal assistance/advice		0.1966***	-0.5596***	-0.1087***
		(12.33)	(8.98)	(4.19)
Number of Observations	49046	49046	49046	49046

The excluded cause is other/NA. The sample and variables are like those reported in Table 26, although the results for some variables are not reported to save space.

Coefficients for Probit indicate marginal effects; * significant at 10%; ** significant at 5%; *** significant at 1%

Table 28: Effects of Counseling Channel On Effectiveness of DMP (Compare to Table 27)

	Effect on likelihood of bankruptcy filing over next two years (Probit model)	*Effect on Bureau bankruptcy risk score two years later (OLS model)*	*Effect on Bureau delinquency risk score two years later (OLS model)*
Cause: income loss / instability	0.0158**	-0.1780***	-0.0752***
	(2.38)	(5.76)	(5.84)
Cause: poor money management	-0.0012	-0.0473	-0.0141
	(0.19)	(1.52)	(1.09)
Cause: death / illness / disability	0.0144*	-0.1603***	-0.0745***
	(1.72)	(4.18)	(4.66)
Cause: domestic issues	0.0209**	-0.2466***	-0.1157***
	(2.09)	(5.41)	(6.09)
Cause: legal	-0.0128	0.0504	-0.0123
	(0.38)	(0.33)	(0.19)
Cause: expenses	0.0466**	0.0939	-0.0023
	(1.99)	(0.91)	(0.05)
Cause: school expenses	-0.0850***	0.1297	-0.0153
	(3.92)	(1.34)	(0.38)
Cause: substance abuse	-0.0250	-0.0593	-0.1195
	(0.50)	(0.24)	(1.17)
Bankruptcy risk score (in 100s)	-0.0219***	0.3566***	0.0410***
	(14.36)	(54.12)	(14.94)
Bankruptcy score in bottom 10% of combined sample	-0.0192***	-0.0824***	0.0164*
	(3.95)	(3.54)	(1.69)
Bankruptcy score in top 10% of combined sample	-0.1211***	1.2359***	0.3279***
	(2.66)	(9.28)	(5.90)
Delinquency risk score (in 100s)	0.0315***	0.4750***	0.6084***
	(8.63)	(28.31)	(86.96)
Delinquency score in bottom 10% of combined sample	0.0045	-0.0084	-0.0024
	(0.65)	(0.28)	(0.19)
Delinquency score in top 10% of combined sample	-0.1067***	0.7360***	0.2295***
	(3.23)	(5.73)	(4.28)
Counseling in person (alternative is telephone)	0.0259***	-0.0154	0.0117
	(4.39)	(0.56)	(1.03)
Log of counselor experience (in months)	-0.0023	0.0047	-0.0043
	(0.90)	(0.40)	(0.89)
Evaluation: Self-manage/Client can handle	-0.0119	0.1025*	0.0327
	(1.02)	(1.89)	(1.45)
Evaluation: DMP recommended by counselor	0.0005	-0.0844*	-0.0199
	(0.05)	(1.84)	(1.04)
DMP started with in-person counseling at outset	-0.0777***	0.1627***	0.1410***
	(11.55)	(4.52)	(9.39)
DMP started with telephone counseling at outset	-0.0762***	0.2111***	0.1593***
	(16.79)	(9.47)	(17.13)
Evaluation: Financial counseling only	0.0271**	-0.1278**	-0.0356
	(2.17)	(2.32)	(1.55)
Evaluation: Referral to other agencies	0.0132	-0.0664	-0.0091
	(1.23)	(1.36)	(0.45)
Evaluation: Referral to legal assistance/advice	0.1957***	-0.5569***	-0.1056***
	(12.28)	(8.94)	(4.06)
Number of Observations	49046	49046	49046

The sample and variables are like those reported in Table 27, although the results for some variables are not reported to save space.

Coefficients for Probit indicate marginal effects; * significant at 10%; ** at 5%; *** at 1%

Section VI: Caveats and Discussion

Several caveats to these findings should be noted. First and foremost, because the sample of participating agencies was not selected to be representative of industry-wide practices, the results cannot be considered representative of the typical experience of counseled consumers nationwide. Instead, they reflect what is obtainable from a group of agencies that emphasize client education and identification of the underlying cause of financial problems. The fact that telephone and face-to-face delivery of counseling services appear to generate equivalent outcomes for consumers in this sample suggests that, when done well, the two delivery channels can be equally effective.

We have presented results on four separate indicators of post-counseling outcomes for consumers, measured two years after the initial counseling visit. Two of these indicators (a commercially available bankruptcy risk score product; a commercially available new account delinquency risk score product) represent general measures of creditworthiness. Two indicators (total non-mortgage balances; number of accounts delinquent) reflect specific margins of credit usage. We also provide results on the incidence of bankruptcy during the two years following counseling. While these indicators examine the consumer's credit experience from a variety of angles, other measures of the impact of the counseling experience would help to provide a more comprehensive picture. In particular, survey evidence on consumer attitudes, knowledge gained, and perceived financial stress, pre and post-counseling, would augment the objective measures of consumer credit performance and provide a more complete picture of counseling's impact.

It would also be helpful to extend the post-counseling observation period for the sample to see if differences emerge in the credit bureau data for telephone and face-to-face clients. For those clients for whom counseling does change their borrowing and payment behavior, two years may not be enough time for the change to be fully reflected in their credit reports and credit scores, especially if prior financial distress was severe and its impact was not yet reflected in the credit report at the time of counseling.

Finally, there is some evidence that consumers' choice of delivery channel is associated with their credit usage patterns and resulting risk profile prior to counseling. The analysis in this report accounted for these differences to the extent allowed by the available data. However, a more detail assessment of borrowers at the time of the initial counseling, either during the interview itself or through supplemental survey work, would allow for more precise controls for this self-selection. Controlling for self-selection would help determine if the equivalence in outcomes across the telephone and face-to-face delivery channels indicated equal effectiveness or was an artifact of initial client characteristics.

The results on the role of Debt Management Plans are particularly intriguing, but self-selection may be partly responsible. Clients who start DMPs outperform all other counseling clients on all of our outcome measures. Admittedly, clients who were recommended for DMPs are in better financial shape than clients who do not qualify. But, the evidence also indicates that between two borrowers who are recommended for a DMP (i.e., borrowers for whom a DMP is both a workable option and the best option), the borrower who actually starts payments in a DMP fares significantly better on all outcome measures at a point two years after counseling. Perhaps there

is some residual self-selection effect driving this result (e.g., borrowers who make a commitment to start a DMP are more motivated to repay than borrowers that do not). Alternatively, perhaps the DMP experience itself (e.g., budgeting to make regular DMP payments; continued interaction with and reinforcement from the counseling agency) generates the improvement in the outcome indicators. Given the significantly improved credit profiles for clients who do start DMPs, this phenomenon deserves closer study. Moreover, if improvement in client credit profiles increases with the time a client stays on a DMP (not examined in Phase 1), a more careful assessment of the factors that contribute to a successful DMP, including agency procedures, seems warranted.

A more detailed client profile at the outset would support analysis of whether some clients would benefit more from a particular delivery channel, as well as the factors that make a DMP more appropriate treatment for some clients as opposed to others. Both types of analysis would facilitate agency efforts to steer clients toward the most effective treatment. Consequently, we recommend development of expanded data collection procedures for a new sample of incoming clients as a core task in Phase 2 of this project.

Appendix: Conversion of Primary Cause Identified by Counselor Into One of Nine Categories

Appendix A: Conversion of Primary Cause Identified by Counselor Into One of Nine Categories

Summary Category	Counselor Reported Primary Category
DEATH/ILLNESS/INJURY/DISABILITY	ACCIDENT/DISABILITY
DEATH/ILLNESS/INJURY/DISABILITY	CARING FOR RELATIVES/FRIENDS
DEATH/ILLNESS/INJURY/DISABILITY	CATASTROPHE
DEATH/ILLNESS/INJURY/DISABILITY	DEATH IN FAMILY
DEATH/ILLNESS/INJURY/DISABILITY	DISABILITY
DEATH/ILLNESS/INJURY/DISABILITY	INJURY/ILLNESS
DEATH/ILLNESS/INJURY/DISABILITY	MEDICAL EXPENSE, ACCIDENT
DEATH/ILLNESS/INJURY/DISABILITY	PREGNANCY/CHILDBIRTH
FRAUD/LEGAL PROBLEMS/EXPENSES	FRAUD ISSUES
FRAUD/LEGAL PROBLEMS/EXPENSES	LEGAL PROBLEMS/EXPENSES
FRAUD/LEGAL PROBLEMS/EXPENSES	NSF CHECKS
HOME/AUTO EXPENSES	AUTO ACCIDENT/REPAIRS/MAINTENANCE
HOME/AUTO EXPENSES	AUTO REPAIRS/MAINTENANCE
HOME/AUTO EXPENSES	HABITAT FOR HUMANITY
HOME/AUTO EXPENSES	HOME EQUITY CONVERSION MORTGAGE
HOME/AUTO EXPENSES	HOME REPAIRS/MAINTENANCE
HOME/AUTO EXPENSES	HOUSING PROBLEMS
HOME/AUTO EXPENSES	INCREASED HOUSING PAYMENT
HOME/AUTO EXPENSES	INCRESED HOUSING PMT
INCOME LOSS/INSTABILITY	CHANGE IN EMPLOYMENT
INCOME LOSS/INSTABILITY	CHANGING EDMP AGENCY
INCOME LOSS/INSTABILITY	CUT IN HOURS
INCOME LOSS/INSTABILITY	EAGAN FLOOD
INCOME LOSS/INSTABILITY	FAILED BUSINESS
INCOME LOSS/INSTABILITY	INCOME REDUCED
INCOME LOSS/INSTABILITY	INSUFFICIENT INCOME
INCOME LOSS/INSTABILITY	LOSS OF GOVERNMENT SUBSIDY
INCOME LOSS/INSTABILITY	LOW INCOME
INCOME LOSS/INSTABILITY	MOVING/RELOCATION EXPENSE
INCOME LOSS/INSTABILITY	NEEDS MORE INCOME
INCOME LOSS/INSTABILITY	PAY CUT/FURLOUGH
INCOME LOSS/INSTABILITY	RELOCATION/MOVE
INCOME LOSS/INSTABILITY	SPORADIC INCOME
INCOME LOSS/INSTABILITY	UNDEREMPLOYMENT
INCOME LOSS/INSTABILITY	UNEMPLOYMENT
MARITAL/DOMESTIC PROBLEMS/SUPPORT	CHILD CARE EXPENSES
MARITAL/DOMESTIC PROBLEMS/SUPPORT	CHILD SUPPORT ISSUES
MARITAL/DOMESTIC PROBLEMS/SUPPORT	DIVORCE/SEPARATION
MARITAL/DOMESTIC PROBLEMS/SUPPORT	DOMESTIC TROUBLE
MARITAL/DOMESTIC PROBLEMS/SUPPORT	LACK OF CHILD SUPPORT
MARITAL/DOMESTIC PROBLEMS/SUPPORT	MANIPULATIVE DAUGHTER
MARITAL/DOMESTIC PROBLEMS/SUPPORT	NO/LOST/INCREASED CHILD SUPPORT
MARITAL/DOMESTIC PROBLEMS/SUPPORT	NONPAYMENT
MARITAL/DOMESTIC PROBLEMS/SUPPORT	PERSONAL
MARITAL/DOMESTIC PROBLEMS/SUPPORT	SPOUSE UNABLE/UNWILLING WORK
MARITAL/DOMESTIC PROBLEMS/SUPPORT	SPOUSE WORKING NOT COST EFFECTIVE
OTHER/NA	ACQUISITION OF ANOTHER AG
OTHER/NA	NA
OTHER/NA	NO CODE / OTHER
OTHER/NA	OTHER
OTHER/NA	RENT CURRENT
OTHER/NA	UNKNOWN
POOR MONEY MGMT	ATTITUDE
POOR MONEY MGMT	BUDGET ADVICE ONLY
POOR MONEY MGMT	CHECKING ACCT PROBLEMS
POOR MONEY MGMT	CLIENT ATTITUDE
POOR MONEY MGMT	CLIENT NEEDS CONSOLIDATIO
POOR MONEY MGMT	CRA ISSUE
POOR MONEY MGMT	CREDIT
POOR MONEY MGMT	CREDIT ADVICE ONLY
POOR MONEY MGMT	CREDIT REPORT COUNSELING
POOR MONEY MGMT	DELINQUENT HOUSING PAYMEN
POOR MONEY MGMT	DELINQUENT UTILITIES
POOR MONEY MGMT	DEPLETED/NO SAVINGS
POOR MONEY MGMT	FIXED INCOME
POOR MONEY MGMT	NO/DEPLETED SAVINGS
POOR MONEY MGMT	POOR MONEY MGMT

TABLE F-2 U.S. BANKRUPTCY COURTS
BUSINESS AND NONBUSINESS BANKRUPTCY CASES COMMENCED, BY CHAPTER OF THE BANKRUPTCY CODE,
DURING THE TWELVE MONTH PERIOD ENDED SEP. 30, 2004

CIRCUIT AND DISTRICT	TOTAL FILINGS	CHAP. 7	CHAP. 11	CHAP. 12	CHAP. 13	TOTAL BUSINESS FILINGS	CHAP. 7	CHAP. 11	CHAP. 12	CHAP. 13	TOTAL NON-BUSINESS FILINGS	CHAP. 7	CHAP. 11	CHAP. 13
TOTAL...	1,618,987	1,153,865	10,368	238	454,412	34,817	20,243	9,436	238	4,799	1,584,170	1,133,622	932	449,613
DC.....	1,987	1,455	23	-	509	45	23	20	-	2	1,942	1,432	3	507
1ST...	45,181	31,963	378	7	12,833	966	583	311	7	65	44,215	31,380	67	12,768
ME.....	4,637	4,154	43	1	439	144	83	41	1	19	4,493	4,071	2	420
MA.....	18,054	15,421	174	-	2,459	320	162	156	-	2	17,734	15,259	18	2,457
NH.....	4,573	4,108	16	-	449	161	137	13	-	11	4,412	3,971	3	438
RI.....	4,222	3,906	18	-	298	78	58	16	-	4	4,144	3,848	2	294
PR.....	13,695	4,374	127	6	9,188	263	143	85	6	29	13,432	4,231	42	9,159
2ND...	94,271	73,691	3,332	12	17,160	4,335	808	3,278	12	161	89,936	72,883	54	16,999
CT.....	11,644	9,557	96	-	1,991	145	69	75	-	1	11,499	9,488	21	1,990
NY,N....	17,474	13,410	48	8	4,008	307	186	46	8	67	17,167	13,224	2	3,941
NY,E....	27,029	21,771	163	-	5,095	291	139	149	-	3	26,738	21,632	14	5,092
NY,S....	20,869	15,661	2,955	1	2,177	3,198	167	2,941	1	14	17,671	15,494	14	2,163
NY,W....	15,482	11,776	57	3	3,645	306	187	54	3	61	15,176	11,589	3	3,584
VT.....	1,773	1,516	13	-	244	88	60	13	-	15	1,685	1,456	-	229
3RD...	104,606	70,209	987	7	33,403	2,182	1,068	870	7	237	102,424	69,141	117	33,166
DE.....	3,740	2,065	290	-	1,385	351	49	287	-	15	3,389	2,016	3	1,370
NJ.....	41,262	27,224	305	3	13,730	704	391	262	3	48	40,558	26,833	43	13,682
PA,E....	24,658	13,835	149	1	10,673	396	208	126	1	61	24,262	13,627	23	10,612
PA,M....	14,246	10,776	44	-	3,426	262	158	38	-	66	13,984	10,618	6	3,360
PA,W....	20,662	16,292	197	3	4,170	465	260	155	3	47	20,197	16,032	42	4,123
VI.....	38	17	2	-	19	4	2	2	-	-	34	15	-	19
4TH...	136,249	87,429	584	14	48,220	2,209	1,476	487	14	230	134,040	85,953	97	47,990
MD.....	30,438	20,882	141	-	9,415	431	256	132	-	43	30,007	20,626	9	9,372
NC,E....	15,054	7,499	68	10	7,477	189	114	56	10	9	14,865	7,385	12	7,468
NC,M....	12,106	5,650	38	-	6,418	183	97	36	-	50	11,923	5,553	2	6,368
NC,W....	10,179	5,688	79	1	4,411	105	38	66	1	-	10,074	5,650	13	4,411
SC.....	15,632	6,722	54	-	8,855	183	122	30	-	30	15,449	6,600	24	8,825
VA,E....	28,921	20,091	110	1	8,718	335	233	84	1	16	28,586	19,858	26	8,702
VA,W....	12,408	10,014	39	1	2,354	521	412	38	1	70	11,887	9,602	1	2,284

WV,N....	4,584	4,331	17	1	235	135	116	12	1	6	4,449	4,215	5	229
WV,S....	6,927	6,552	38	-	337	127	88	33	-	6	6,800	6,464	5	331
5TH...	145,039	81,839	1,068	26	62,101	3,917	2,116	972	26	798	141,122	79,723	96	61,303
LA,E....	9,982	6,741	48	-	3,193	127	89	37	-	1	9,855	6,652	11	3,192
LA,M....	4,235	2,939	23	1	1,272	37	15	19	1	2	4,198	2,924	4	1,270
LA,W....	15,768	8,753	38	9	6,967	431	192	35	9	194	15,337	8,561	3	6,773
MS,N....	8,382	5,751	25	2	2,604	70	40	25	2	3	8,312	5,711	-	2,601
MS,S....	12,969	8,577	38	-	4,354	113	64	33	-	16	12,856	8,513	5	4,338
TX,N....	32,560	15,458	358	8	16,733	1,267	660	341	8	255	31,293	14,798	17	16,478
TX,E....	13,204	7,719	79	4	5,401	367	196	76	4	90	12,837	7,523	3	5,311
TX,S....	26,637	13,728	242	-	12,667	701	427	208	-	66	25,936	13,301	34	12,601
TX,W....	21,302	12,173	217	2	8,910	804	433	198	2	171	20,498	11,740	19	8,739
6TH...	245,454	170,221	777	21	74,431	2,912	1,842	682	21	363	242,542	168,379	95	74,068
KY,E....	13,089	10,955	27	4	2,103	146	102	26	4	14	12,943	10,853	1	2,089
KY,W....	15,466	12,008	97	2	3,359	176	73	91	2	10	15,290	11,935	6	3,349
MI,E....	46,935	31,923	168	2	14,839	414	227	156	2	26	46,521	31,696	12	14,813
MI,W....	16,947	13,473	46	2	3,425	232	163	42	2	24	16,715	13,310	4	3,401
OH,N....	48,436	39,986	83	2	8,365	849	664	78	2	105	47,587	39,322	5	8,260
OH,S....	42,120	31,446	109	4	10,561	544	315	102	4	123	41,576	31,131	7	10,438
TN,E....	19,926	12,663	70	3	7,190	263	168	60	3	32	19,663	12,495	10	7,158
TN,M....	16,038	9,427	109	2	6,500	156	79	65	2	10	15,882	9,348	44	6,490
TN,W....	26,497	9,340	68	-	18,089	132	51	62	-	19	26,365	8,089	6	18,070
7TH...	163,790	127,811	419	33	35,535	2,116	1,601	359	22	131	161,674	126,210	60	35,404
IL,N....	55,100	40,295	196	-	14,608	599	427	169	-	2	54,501	39,868	27	14,606
IL,C....	15,763	13,498	19	3	2,241	158	118	16	5	19	15,605	13,380	3	2,222
IL,S....	9,802	6,914	21	28	2,855	131	81	16	10	22	9,671	6,833	5	2,833
IN,N....	21,130	17,596	37	3	3,494	151	111	33	3	4	20,979	17,485	4	3,490
IN,S....	34,551	26,661	79	1	7,810	353	253	70	1	29	34,198	26,408	9	7,781
WI,E....	18,222	14,786	21	-	3,415	194	155	21	-	18	18,028	14,631	-	3,397
WI,W....	9,222	8,061	46	3	1,112	530	456	34	3	37	8,692	7,605	12	1,075
8TH...	107,543	81,138	330	44	26,030	2,869	2,061	308	44	455	104,674	79,077	22	25,575
AR,E....	15,665	8,444	35	6	7,180	351	124	34	6	87	15,414	8,320	1	7,093
AR,W....	8,731	5,926	19	-	2,786	153	89	18	-	46	8,578	5,837	1	2,740
IA,N....	5,046	4,854	15	1	176	236	213	14	1	8	4,810	4,641	1	168
IA,S....	7,942	7,507	15	2	418	125	103	15	2	5	7,817	7,404	-	413
MN.....	18,451	14,639	111	10	3,691	1,375	1,031	111	10	223	17,076	13,603	-	3,468
MO,E....	19,850	13,501	39	4	6,305	165	113	34	4	13	19,685	13,388	5	6,292
MO,W....	17,796	14,500	38	5	3,253	183	125	34	5	19	17,613	14,375	4	3,234
NE.....	8,906	6,954	39	7	1,906	191	120	32	7	32	8,715	6,834	7	1,874
ND.....	2,294	2,175	5	5	109	93	73	5	5	10	2,201	2,102	-	99
SD.....	2,862	2,638	14	4	206	97	70	11	4	12	2,765	2,568	3	194
9TH...	260,665	217,303	1,280	38	42,038	6,729	4,403	1,092	38	1,192	253,936	212,900	188	40,846

AK.....	1,468	1,346	9	-	113	72	56	9	-	8	1,395	1,260	-	135
AZ.....	31,686	25,955	213	-	5,517	481	252	169	-	69	31,205	25,703	44	5,457
CA,N....	22,332	16,296	180	1	5,855	1,013	556	142	1	314	21,319	15,740	38	5,541
CA,E....	29,581	24,918	103	10	4,548	1,008	657	99	10	240	28,573	24,261	4	4,308
CA,C....	64,565	57,795	329	4	6,455	1,758	1,343	294	4	115	62,827	56,452	35	6,340
CA,S....	11,366	9,564	46	-	1,736	186	129	34	-	17	11,186	9,455	12	1,719
HI.....	3,237	2,837	23	-	376	51	30	16	-	5	3,186	2,807	7	371
ID.....	9,445	8,210	25	9	1,202	162	111	18	8	25	9,283	8,099	7	1,177
MT.....	4,376	3,897	15	8	456	105	74	14	8	9	4,271	3,823	1	447
NV.....	18,397	14,281	150	-	3,996	276	140	110	-	26	18,121	14,141	10	3,970
OR.....	24,589	20,859	42	3	3,915	948	621	42	3	282	23,641	20,008	-	3,633
WA,E....	9,693	7,618	52	4	2,019	219	149	44	4	22	9,474	7,469	8	1,997
WA,W....	29,522	23,617	122	-	5,783	445	276	100	-	69	29,077	23,341	22	5,714
GUAM....	371	334	1	-	36	7	6	1	-	-	364	328	-	36
NMI.....	17	16	-	-	1	3	3	-	-	-	14	13	-	1
10TH..	104,626	87,862	342	31	16,429	2,861	2,192	313	31	323	101,765	85,630	29	16,106
CO.....	27,879	24,925	89	2	2,862	777	639	80	2	55	27,102	24,286	9	2,807
KS.....	16,401	13,331	48	11	3,011	263	186	42	11	24	16,138	13,145	6	2,987
NM.....	9,360	8,481	40	2	837	685	573	33	2	77	8,675	7,908	7	760
OK,N....	7,694	6,945	18	2	729	243	196	17	2	28	7,451	6,749	1	701
OK,E....	5,102	4,680	16	1	405	83	50	16	1	16	5,019	4,630	-	389
OK,W....	14,440	12,485	30	13	1,911	274	209	30	13	21	14,166	12,276	-	1,890
UT.....	21,312	14,747	83	-	6,482	481	305	83	-	93	20,831	14,442	-	6,389
WY.....	2,438	2,228	18	-	192	55	34	12	-	9	2,383	2,194	6	183
11TH..	209,676	122,994	848	16	85,723	3,676	2,070	744	16	842	205,900	120,914	104	84,881
AL,N....	25,807	13,388	103	-	12,316	477	377	87	-	13	25,630	13,311	16	12,303
AL,M....	8,545	4,060	11	1	4,473	79	58	9	1	11	8,466	4,002	2	4,462
AL,S....	7,555	2,958	26	1	4,570	53	23	20	1	9	7,502	2,935	6	4,561
FL,N....	6,835	5,454	40	-	1,341	94	53	35	-	6	6,741	5,401	5	1,335
FL,M....	53,535	38,842	299	1	14,482	509	299	176	3	33	53,026	38,543	33	14,449
FL,S....	28,000	21,515	166	-	6,316	599	412	148	-	36	27,401	21,103	18	6,280
GA,N....	45,610	24,374	239	-	20,996	1,898	1,039	218	-	640	43,712	23,335	21	20,356
GA,M....	17,635	8,149	33	9	9,644	135	68	31	9	27	17,700	8,081	2	9,617
GA,S....	15,854	4,244	21	4	11,585	132	41	20	4	67	15,722	4,203	1	11,518

NOTE: ALL TOTALS ABOVE INCLUDE THE FOLLOWING CASES, WHICH MAY BE BUSINESS AND/OR NON-BUSINESS, NOT REFLECTED ELSEWHERE:

NY,S.... SECTION 304 = 75	NY,W.... SECTION 304 = 01	SC..... SECTION 304 = 01	
VA,E.... SECTION 304 = 01	LA,W.... CHAPTER 9 = 01	TX,N.... SECTION 304 = 03	
TX,E.... CHAPTER 9 = 01	MI,E.... SECTION 304 = 03	MI,W.... SECTION 304 = 01	
IL,N.... SECTION 304 = 01	IL,S.... CHAPTER 9 = 02	MO,E.... CHAPTER 9 = 01	
AZ..... SECTION 304 = 01	CA,E.... CHAPTER 9 = 01	CA,E.... SECTION 304 = 01	
CA,C.... CHAPTER 9 = 01	CA,C.... SECTION 304 = 01	HI..... SECTION 304 = 01	
CO..... SECTION 304 = 01	OK,W.... CHAPTER 9 = 01	FL,M.... SECTION 304 = 01	
FL,S.... SECTION 304 = 03	GA,N.... SECTION 304 = 01		

source: Administrative Office of the U.S. Courts, Bankruptcy Statistics, http://www.uscourts.gov/bkrptcystats/statistics.htm#fis

TABLE F-2 U.S. BANKRUPTCY COURTS
BUSINESS AND NONBUSINESS BANKRUPTCY CASES COMMENCED, BY CHAPT
DURING THE TWELVE MONTH PERIOD ENDED SEP. 30,

CIRCUIT AND DISTRICT	TOTAL FILINGS	CHAP. 7	CHAP. 11	CHAP. 12	CHAP. 13	TOTAL BUSINESS FILINGS	CHAP. 7	CHAP. 11
TOTAL...	1,782,643	1,346,201	6,637	364	429,316	34,222	23,313	5,776
DC.....	1,951	1,607	25	-	318	43	21	20
1ST...	50,451	37,489	328	14	12,618	1,487	944	288
ME.....	5,459	5,033	20	2	402	119	81	20
MA.....	21,952	19,236	140	-	2,576	373	232	130
NH.....	5,341	4,840	33	1	467	511	421	30
RI.....	4,855	4,581	16	1	257	89	70	15
PR.....	12,844	3,799	119	10	8,916	395	140	93
2ND...	105,373	88,715	763	23	15,784	1,761	801	706
CT.....	12,777	10,985	41	-	1,744	104	67	28
NY,N....	20,525	15,838	42	7	4,637	261	152	40
NY,E....	30,481	26,835	162	-	3,484	290	140	143
NY,S....	21,705	19,394	456	3	1,772	701	170	441
NY,W....	17,937	13,973	58	11	3,895	342	227	52
VT.....	1,948	1,690	4	2	252	63	45	2
3RD...	113,761	82,876	801	10	30,072	2,125	1,169	695
DE.....	3,798	2,343	172	-	1,281	226	52	170
NJ.....	42,829	30,879	285	-	11,665	679	378	235
PA,E....	25,570	16,323	132	1	9,114	379	220	113
PA,M....	16,337	12,600	68	1	3,668	359	213	64
PA,W....	25,180	20,705	139	8	4,328	476	305	108
VI.....	47	26	5	-	16	6	1	5
4TH...	140,643	95,124	414	14	45,087	2,003	1,351	334
MD.....	30,448	22,585	109	-	7,754	616	422	91
NC,E....	15,905	8,719	43	4	7,137	183	111	36
NC,M....	12,527	6,596	20	-	5,911	308	189	19
NC,W....	11,485	7,223	36	-	4,225	84	48	34
SC.....	15,209	6,811	53	3	8,342	158	100	33
VA,E....	28,030	19,441	86	1	8,502	280	186	74
VA,W....	12,557	9,906	21	4	2,625	144	116	14
WV,N....	5,837	5,528	20	-	289	167	134	19
WV,S....	8,645	8,315	26	2	302	63	45	14
5TH...	158,791	98,179	813	44	59,749	4,086	2,546	732
LA,E....	10,376	7,405	47	1	2,923	131	88	41
LA,M....	4,542	3,361	24	1	1,156	45	23	19
LA,W....	17,216	9,297	48	13	7,857	524	251	45
MS,N....	9,064	6,203	30	8	2,823	78	40	30
MS,S....	12,778	8,532	31	2	4,213	103	67	26

TX,N....	35,944	19,954	230	12	15,744	1,263	790	218
TX,E....	14,869	9,747	66	2	5,054	390	265	58
TX,S....	30,879	18,382	250	2	12,245	821	535	217
TX,W....	23,123	15,298	87	3	7,734	731	487	78
6TH...	281,334	207,571	748	37	72,978	3,456	2,360	648
KY,E....	15,311	13,029	17	8	2,257	163	125	17
KY,W....	17,792	14,056	57	5	3,674	174	106	52
MI,E....	55,845	42,017	227	5	13,596	519	289	209
MI,W....	19,915	16,956	40	9	2,910	328	247	38
OH,N....	59,058	49,772	83	5	9,198	1,131	900	75
OH,S....	50,355	38,882	107	-	11,366	631	402	104
TN,E....	20,708	14,168	50	2	6,488	162	108	41
TN,M....	15,836	9,761	108	3	5,964	201	115	65
TN,W....	26,514	8,930	59	-	17,525	147	68	47
7TH...	187,036	150,658	461	35	35,880	2,361	1,805	383
IL,N....	61,548	48,334	205	3	13,006	677	491	171
IL,C....	18,244	15,762	37	8	2,437	182	130	32
IL,S....	11,368	7,887	18	2	3,460	61	44	10
IN,N....	24,012	20,185	43	3	3,780	166	120	35
IN,S....	39,146	30,385	100	6	8,655	464	335	85
WI,E....	22,021	18,562	22	2	3,435	244	202	21
WI,W....	10,697	9,543	36	11	1,107	567	483	29
8TH...	126,620	99,399	200	64	26,956	3,207	2,535	187
AR,E....	17,736	9,980	21	4	7,731	221	131	18
AR,W....	9,872	6,839	16	3	3,013	148	83	13
IA,N....	6,314	6,075	10	4	225	252	229	10
IA,S....	9,769	9,160	9	2	598	129	110	9
MN.....	22,025	18,368	40	4	3,613	1,579	1,329	39
MO,E....	22,765	16,924	25	1	5,815	161	121	22
MO,W....	21,216	17,684	37	1	3,494	209	152	35
NE.....	10,515	8,414	32	30	2,039	272	188	31
ND.....	2,878	2,702	4	10	162	77	60	4
SD.....	3,530	3,253	6	5	266	159	132	6
9TH...	279,461	243,034	1,043	52	35,325	6,491	4,613	889
AK.....	1,885	1,723	14	1	147	71	46	13
AZ.....	35,570	30,839	162	2	4,566	498	311	138
CA,N....	24,490	18,987	137	1	5,364	941	586	103
CA,E....	30,649	26,955	66	8	3,620	846	617	59
CA,C....	67,721	63,436	274	2	4,005	1,617	1,289	244
CA,S....	13,012	11,292	49	-	1,671	196	142	41
HI.....	3,715	3,368	19	-	328	72	52	17
ID.....	10,462	9,124	22	8	1,308	134	85	19
MT.....	4,929	4,484	18	8	419	117	85	16
NV.....	18,220	14,767	115	-	3,338	310	177	108
OR.....	27,909	23,914	29	11	3,955	968	703	27
WA,E....	10,364	8,512	37	7	1,808	265	195	31
WA,W....	30,172	25,308	99	4	4,761	446	317	71
GUAM....	330	295	2	-	33	10	8	2
NMI.....	32	30	-	-	2	-	-	-
10TH..	119,195	102,793	280	51	16,069	3,319	2,666	251
CO.....	34,772	31,769	103	7	2,893	879	732	98

KS.....	18,936	15,498	27	24	3,387	345	241	21
NM.....	10,921	10,155	45	4	717	784	680	38
OK,N....	8,864	8,131	13	-	720	318	274	13
OK,E....	5,504	5,053	4	5	440	89	71	-
OK,W....	16,854	14,767	30	9	2,048	420	348	27
UT.....	20,611	14,851	46	2	5,712	417	276	42
WY.....	2,733	2,569	12	-	152	67	44	12
11TH..	218,027	138,756	761	20	78,480	3,883	2,502	643
AL,N....	28,439	15,870	74	2	12,492	156	97	49
AL,M....	9,132	4,714	37	-	4,381	98	48	35
AL,S....	7,313	3,255	15	-	4,043	37	23	11
FL,N....	6,659	5,400	21	-	1,238	79	61	15
FL,M....	56,332	43,348	207	-	12,776	771	526	186
FL,S....	30,907	25,735	138	-	5,028	528	397	118
GA,N....	47,865	28,096	197	2	19,568	1,927	1,209	167
GA,M....	17,027	8,274	35	11	8,707	145	85	31
GA,S....	14,353	4,064	37	5	10,247	142	56	31

NOTE: ALL TOTALS ABOVE INCLUDE THE FOLLOWING CASES, WHICH MAY BE BUSINESS A

DC.....	SECTION 304 = 001	ME.....	SECTION 304 = 002	CT.....	SECTION 3
NY,N....	CHAPTER 9 = 001	NY,S....	SECTION 304 = 080	DE.....	SECTION 3
NC,E....	CHAPTER 9 = 001	NC,E....	SECTION 304 = 001	NC,W....	SECTION 3
VA,W....	SECTION 304 = 001	LA,W....	SECTION 304 = 001	TX,N....	SECTION 3
TX,W....	CHAPTER 9 = 001	IL,S....	CHAPTER 9 = 001	IN,N....	SECTION 3
AR,W....	CHAPTER 9 = 001	AZ.....	SECTION 304 = 001	CA,N....	SECTION 3
CA,C....	CHAPTER 9 = 001	CA,C....	SECTION 304 = 003	HI.....	SECTION 3
OK,E....	CHAPTER 9 = 002	AL,N....	CHAPTER 9 = 001	FL,M....	SECTION 3
FL,S....	SECTION 304 = 006	GA,N....	SECTION 304 = 002		

source: Administrative Office of the U.S. Courts, Bankruptcy Statistics, http://www.us

'ER OF THE BANKRUPTCY CODE,
2005

CHAP. 12	CHAP. 13	TOTAL NON-BUSINESS FILINGS	CHAP. 7	CHAP. 11	CHAP. 13
364	4,649	1,748,421	1,322,888	861	424,667
-	1	1,908	1,586	5	317
14	241	48,964	36,545	40	12,377
2	16	5,340	4,952	-	386
-	11	21,579	19,004	10	2,565
1	59	4,830	4,419	3	408
1	3	4,766	4,511	1	254
10	152	12,449	3,659	26	8,764
23	143	103,612	87,914	57	15,641
-	2	12,673	10,918	13	1,742
7	61	20,264	15,686	2	4,576
-	7	30,191	26,695	19	3,477
3	7	21,004	19,224	15	1,765
11	52	17,595	13,746	6	3,843
2	14	1,885	1,645	2	238
10	249	111,636	81,707	106	29,823
-	2	3,572	2,291	2	1,279
-	66	42,150	30,501	50	11,599
1	45	25,191	16,103	19	9,069
1	81	15,978	12,387	4	3,587
8	55	24,704	20,400	31	4,273
-	-	41	25	-	16
14	300	138,640	93,773	80	44,787
-	103	29,832	22,163	18	7,651
4	30	15,722	8,608	7	7,107
-	100	12,219	6,407	1	5,811
-	1	11,401	7,175	2	4,224
3	22	15,051	6,711	20	8,320
1	19	27,750	19,255	12	8,483
4	9	12,413	9,790	7	2,616
-	14	5,670	5,394	1	275
2	2	8,582	8,270	12	300
44	758	154,705	95,633	81	58,991
1	1	10,245	7,317	6	2,922
1	2	4,497	3,338	5	1,154
13	214	16,692	9,046	3	7,643
8	-	8,986	6,163	-	2,823
2	8	12,675	8,465	5	4,205

12	239	34,681	19,164	12	15,505
2	65	14,479	9,482	8	4,989
2	67	30,058	17,847	33	12,178
3	162	22,392	14,811	9	7,572
37	411	277,878	205,211	100	72,567
8	13	15,148	12,904	-	2,244
5	11	17,618	13,950	5	3,663
5	16	55,326	41,728	18	13,580
9	34	19,587	16,709	2	2,876
5	151	57,927	48,872	8	9,047
-	125	49,724	38,480	3	11,241
2	11	20,546	14,060	9	6,477
3	18	15,635	9,646	43	5,946
-	32	26,367	8,862	12	17,493
35	136	184,675	148,853	78	35,744
3	12	60,871	47,843	34	12,994
8	12	18,062	15,632	5	2,425
2	4	11,307	7,843	8	3,456
3	7	23,846	20,065	8	3,773
6	38	38,682	30,050	15	8,617
2	19	21,777	18,360	1	3,416
11	44	10,130	9,060	7	1,063
64	420	123,413	96,864	13	26,536
4	68	17,515	9,849	3	7,663
3	48	9,724	6,756	3	2,965
4	9	6,062	5,846	-	216
2	8	9,640	9,050	-	590
4	207	20,446	17,039	1	3,406
1	17	22,604	16,803	3	5,798
1	21	21,007	17,532	2	3,473
30	23	10,243	8,226	1	2,016
10	3	2,801	2,642	-	159
5	16	3,371	3,121	-	250
52	930	272,970	238,421	154	34,395
1	11	1,814	1,677	1	136
2	46	35,072	30,528	24	4,520
1	250	23,549	18,401	34	5,114
8	162	29,803	26,338	7	3,458
2	78	66,104	62,147	30	3,927
-	13	12,816	11,150	8	1,658
-	2	3,644	3,316	2	326
8	22	10,328	9,039	3	1,286
8	8	4,812	4,399	2	411
-	25	17,910	14,590	7	3,313
11	227	26,941	23,211	2	3,728
7	32	10,099	8,317	6	1,776
4	54	29,726	24,991	28	4,707
-	-	320	287	-	33
-	-	32	30	-	2
51	349	115,876	100,127	29	15,720
7	42	33,893	31,037	5	2,851

24	59	18,591	15,257	6	3,328
4	62	10,137	9,475	7	655
-	31	8,546	7,857	-	689
5	11	5,415	4,982	4	429
9	36	16,434	14,419	3	2,012
2	97	20,194	14,575	4	5,615
-	11	2,666	2,525	-	141
20	711	214,144	136,254	118	77,769
2	7	28,283	15,773	25	12,485
-	15	9,034	4,666	2	4,366
-	3	7,276	3,232	4	4,040
-	3	6,580	5,339	6	1,235
-	58	55,561	42,822	21	12,718
-	10	30,379	25,338	20	5,018
2	547	45,938	26,887	30	19,021
11	18	16,882	8,189	4	8,689
5	50	14,211	4,008	6	10,197

ND/OR NON-BUSINESS, NOT REFLECTED ELSEWHERE:
04 = 007
04 = 002
04 = 001
04 = 004
04 = 001
04 = 001
04 = 001
04 = 001

courts.gov/bnkrpctystats/statistics.htm#fiscal (last visited Oct. 20, 2009)

TABLE F-2 U.S. BANKRUPTCY COURTS
BUSINESS AND NONBUSINESS BANKRUPTCY CASES COMMENCED, BY CHAPT
DURING THE TWELVE MONTH PERIOD ENDED SEP. 30,

CIRCUIT AND DISTRICT	TOTAL FILINGS	PREDOMINANT NATURE OF DEBT(1) CHAP. 7	CHAP. 11	CHAP. 12	CHAP. 13	TOTAL BUSINESS FILINGS	CHAP. 7	CHAP. 11
TOTAL...	801,269	484,162	5,888	361	310,802	25,925	16,914	5,317
DC.....	670	340	15	-	315	32	16	14
1ST...	27,981	15,793	289	14	11,885	1,138	664	256
ME.....	2,143	1,687	15	1	440	130	96	15
MA.....	13,011	8,463	156	2	4,390	339	191	138
NH.....	2,804	1,977	21	3	803	331	228	20
RI.....	2,521	1,931	11	-	579	82	66	10
PR.....	7,502	1,735	86	8	5,673	256	83	73
2ND...	45,244	32,124	573	23	12,489	1,587	824	536
CT.....	5,572	3,919	65	1	1,587	210	139	59
NY,N....	11,262	7,658	38	15	3,551	270	151	37
NY,E....	11,800	8,591	175	-	3,034	348	163	164
NY,S....	7,251	5,461	265	-	1,492	475	181	249
NY,W....	8,510	5,887	29	4	2,588	217	146	26
VT.....	849	608	1	3	237	67	44	1
3RD...	49,735	29,884	841	18	18,989	2,036	979	801
DE.....	1,897	947	220	-	727	288	62	219
NJ.....	18,702	11,388	387	3	6,924	802	381	360
PA,E....	9,778	4,992	66	-	4,720	274	172	63
PA,M....	7,332	4,506	27	8	2,791	197	109	27
PA,W....	12,001	8,035	136	7	3,823	464	249	127
VI.....	25	16	5	-	4	11	6	5
4TH...	61,191	31,607	430	13	29,139	1,687	1,113	359
MD.....	12,509	6,448	135	1	5,925	389	225	105
NC,E....	7,703	2,974	52	3	4,674	182	99	49
NC,M....	5,907	2,554	25	3	3,325	182	102	25
NC,W....	5,810	3,162	47	-	2,601	166	121	39
SC.....	7,139	2,292	49	1	4,795	124	78	38
VA,E....	12,528	7,026	84	2	5,416	363	264	69
VA,W....	5,365	3,415	12	1	1,937	144	120	12
WV,N....	1,646	1,429	8	1	208	82	66	7
WV,S....	2,584	2,307	18	1	258	55	38	15
5TH...	66,810	27,876	641	72	38,219	3,053	1,869	609
LA,E....	2,523	1,262	23	10	1,228	90	60	18
LA,M....	1,785	846	10	-	929	40	25	10
LA,W....	9,226	2,529	62	26	6,609	337	80	59

MS,N....	4,807	2,167	15	5	2,620	123	86	15
MS,S....	5,982	2,540	30	5	3,406	123	74	27
TX,N....	14,917	6,004	189	5	8,719	836	522	185
TX,E....	5,775	2,950	44	9	2,772	363	281	41
TX,S....	12,551	5,037	174	9	7,330	655	414	164
TX,W....	9,244	4,541	94	3	4,606	486	327	90
6TH...	146,328	87,802	500	28	57,998	3,157	2,271	450
KY,E....	7,281	5,117	33	1	2,130	145	99	33
KY,W....	8,935	6,231	14	1	2,689	125	90	14
MI,E....	33,799	22,301	140	12	11,346	739	551	130
MI,W....	10,007	8,125	32	3	1,847	371	301	32
OH,N....	26,417	18,089	63	-	8,265	663	493	59
OH,S....	22,110	13,852	64	2	8,192	566	388	62
TN,E....	11,377	5,996	34	3	5,344	200	141	31
TN,M....	9,476	4,279	82	5	5,110	191	111	60
TN,W....	16,926	3,812	38	1	13,075	157	97	29
7TH...	83,755	56,433	336	31	26,954	1,859	1,355	299
IL,N....	26,807	16,997	160	-	9,650	650	490	144
IL,C....	7,257	5,478	22	2	1,755	180	138	21
IL,S....	5,083	2,450	9	4	2,620	121	64	9
IN,N....	11,231	8,090	50	4	3,087	196	136	43
IN,S....	18,425	12,207	54	3	6,160	330	247	48
WI,E....	9,947	7,057	20	4	2,866	203	160	18
WI,W....	5,005	4,154	21	14	816	179	120	16
8TH...	57,030	39,130	171	52	17,677	1,759	1,351	162
AR,E....	7,344	3,440	22	9	3,873	191	124	19
AR,W....	4,150	2,219	22	3	1,906	155	102	22
IA,N....	2,354	2,177	5	4	168	110	97	5
IA,S....	4,306	3,709	7	1	589	121	103	7
MN.....	11,139	8,749	42	9	2,339	507	427	41
MO,E....	9,919	6,145	16	3	3,755	153	119	15
MO,W....	10,222	7,074	32	4	3,112	177	119	31
NE.....	5,204	3,569	20	12	1,603	203	153	17
ND.....	1,090	951	1	6	132	58	45	1
SD.....	1,302	1,097	4	1	200	84	62	4
9TH...	113,541	81,740	1,071	38	30,684	4,782	3,271	913
AK.....	696	562	13	1	120	64	40	13
AZ.....	9,749	7,405	202	-	2,141	398	192	183
CA,N....	11,214	6,416	169	2	4,624	611	381	114
CA,E....	15,594	11,328	84	11	4,170	691	471	73
CA,C....	29,106	22,196	287	-	6,621	1,507	1,166	249
CA,S....	7,037	5,497	43	-	1,497	304	247	38
HI.....	1,281	1,035	14	1	230	46	28	13
ID.....	3,716	2,961	18	6	731	99	69	16
MT.....	1,934	1,597	12	8	317	53	34	10
NV.....	9,445	5,747	103	-	3,595	273	161	98
OR.....	8,993	6,572	26	2	2,393	281	191	22
WA,E....	4,192	3,154	21	3	1,014	151	98	19
WA,W....	10,440	7,141	77	4	3,218	294	185	63
GUAM....	126	113	2	-	11	7	5	2
NMI.....	18	16	-	-	2	3	3	-
10TH..	41,132	31,086	202	35	9,806	1,490	1,127	190

CO.....	14,238	11,855	73	1	2,309	586	480	68
KS.....	7,730	5,145	24	21	2,540	219	138	23
NM.....	3,232	2,822	25	3	381	127	91	22
OK,N....	2,648	2,254	3	-	391	127	113	2
OK,E....	1,477	1,198	24	2	251	72	42	23
OK,W....	4,841	3,479	26	7	1,329	166	124	26
UT.....	6,182	3,688	21	1	2,472	159	113	20
WY.....	784	645	6	-	133	34	26	6
11TH..	107,852	50,347	819	37	56,647	3,345	2,074	728
AL,N....	14,159	5,641	67	5	8,446	158	79	53
AL,M....	5,274	1,384	18	4	3,868	90	54	15
AL,S....	3,743	994	21	1	2,727	42	18	18
FL,N....	2,688	1,927	21	3	737	119	88	17
FL,M....	23,027	13,657	202	6	9,162	883	625	182
FL,S....	10,857	7,451	230	2	3,172	669	430	210
GA,N....	30,768	14,535	222	-	16,011	1,096	598	197
GA,M....	9,217	3,196	13	7	6,001	146	99	12
GA,S....	8,119	1,562	25	9	6,523	142	83	24

NOTE: THESE FIGURES INCLUDE THE FOLLOWING CASES NOT REFLECTED ELSEWHERE:

CHAPTER 9	NY,S.... = 001	MS,S.... = 001	CA,N.... = 002
	NM..... = 001	OK,E.... = 002	
CHAPTER 15	NY,S.... = 032	NY,W.... = 002	DE..... = 003
	SC..... = 002	TX,S.... = 001	IN,S.... = 001
	AZ..... = 001	CA,N.... = 001	CA,E.... = 001
	CA,C.... = 002	HI..... = 001	FL,S.... = 002

CHAPTER 15 WAS ADDED AND SECTION 304 WAS TERMINATED BY CHANGES IN THE BANKRU
(1) SECTION 101 OF THE U.S. BANKRUPTCY CODE DEFINES CONSUMER (NONBUSINESS) D
PRIMARILY FOR A PERSONAL, FAMILY, OR HOUSEHOLD PURPOSE. IF THE DEBTOR IS A
TO OPERATION OF A BUSINESS PREDOMINATES, THE NATURE OF THE DEBT IS BUSINESS.

source: Administrative Office of the U.S. Courts, Bankruptcy Statistics, http://www.us

'ER OF THE BANKRUPTCY CODE,
2007

			PREDOMINANT NATURE OF DEBT(1)		
CHAP. 12	CHAP. 13	TOTAL NON-BUSINESS FILINGS	CHAP. 7	CHAP. 11	CHAP. 13
361	3,281	775,344	467,248	571	307,521
-	2	638	324	1	313
14	204	26,843	15,129	33	11,681
1	18	2,013	1,591	-	422
2	8	12,672	8,272	18	4,382
3	80	2,473	1,749	1	723
-	6	2,439	1,865	1	573
8	92	7,246	1,652	13	5,581
23	170	43,657	31,300	37	12,319
1	11	5,362	3,780	6	1,576
15	67	10,992	7,507	1	3,484
-	21	11,452	8,428	11	3,013
-	13	6,776	5,280	16	1,479
4	39	8,293	5,741	3	2,549
3	19	782	564	-	218
18	235	47,699	28,905	40	18,754
-	4	1,609	885	1	723
3	58	17,900	11,007	27	6,866
-	39	9,504	4,820	3	4,681
8	53	7,135	4,397	-	2,738
7	81	11,537	7,786	9	3,742
-	-	14	10	-	4
13	201	59,504	30,494	71	28,938
1	58	12,120	6,223	30	5,867
3	31	7,521	2,875	3	4,643
3	52	5,725	2,452	-	3,273
-	6	5,644	3,041	8	2,595
1	6	7,015	2,214	11	4,789
2	28	12,165	6,762	15	5,388
1	11	5,221	3,295	-	1,926
1	8	1,564	1,363	1	200
1	1	2,529	2,269	3	257
72	501	63,757	26,007	32	37,718
10	2	2,433	1,202	5	1,226
-	5	1,745	821	-	924
26	172	8,889	2,449	3	6,437

5	17	4,684	2,081	-	2,603
5	16	5,859	2,466	3	3,390
5	124	14,081	5,482	4	8,595
9	32	5,412	2,669	3	2,740
9	67	11,896	4,623	10	7,263
3	66	8,758	4,214	4	4,540
28	408	143,171	85,531	50	57,590
1	12	7,136	5,018	-	2,118
1	20	8,810	6,141	-	2,669
12	46	33,060	21,750	10	11,300
3	35	9,636	7,824	-	1,812
-	111	25,754	17,596	4	8,154
2	114	21,544	13,464	2	8,078
3	25	11,177	5,855	3	5,319
5	15	9,285	4,168	22	5,095
1	30	16,769	3,715	9	13,045
31	173	81,896	55,078	37	26,781
-	16	26,157	16,507	16	9,634
2	19	7,077	5,340	1	1,736
4	44	4,962	2,386	-	2,576
4	13	11,035	7,954	7	3,074
3	31	18,095	11,960	6	6,129
4	21	9,744	6,897	2	2,845
14	29	4,826	4,034	5	787
52	194	55,271	37,779	9	17,483
9	39	7,153	3,316	3	3,834
3	28	3,995	2,117	-	1,878
4	4	2,244	2,080	-	164
1	10	4,185	3,606	-	579
9	30	10,632	8,322	1	2,309
3	16	9,766	6,026	1	3,739
4	23	10,045	6,955	1	3,089
12	21	5,001	3,416	3	1,582
6	6	1,032	906	-	126
1	17	1,218	1,035	-	183
38	553	108,759	78,469	158	30,131
1	10	632	522	-	110
-	22	9,351	7,213	19	2,119
2	111	10,603	6,035	55	4,513
11	135	14,903	10,857	11	4,035
-	90	27,599	21,030	38	6,531
-	19	6,733	5,250	5	1,478
1	4	1,235	1,007	1	226
6	8	3,617	2,892	2	723
8	1	1,881	1,563	2	316
-	14	9,172	5,586	5	3,581
2	66	8,712	6,381	4	2,327
3	31	4,041	3,056	2	983
4	42	10,146	6,956	14	3,176
-	-	119	108	-	11
-	-	15	13	-	2
35	135	39,642	29,959	12	9,671

1	37	13,652	11,375	5	2,272
21	37	7,511	5,007	1	2,503
3	10	3,105	2,731	3	371
-	12	2,521	2,141	1	379
2	3	1,405	1,156	1	248
7	9	4,675	3,355	-	1,320
1	25	6,023	3,575	1	2,447
-	2	750	619	-	131
37	505	104,507	48,273	91	56,142
5	21	14,001	5,562	14	8,425
4	17	5,184	1,330	3	3,851
1	5	3,701	976	3	2,722
3	11	2,569	1,839	4	726
6	70	22,144	13,032	20	9,092
2	26	10,188	7,021	20	3,146
-	301	29,672	13,937	25	15,710
7	28	9,071	3,097	1	5,973
9	26	7,977	1,479	1	6,497

)PTCY LAWS EFFECTIVE OCTOBER 17, 2005.
)EBT AS THAT INCURRED BY AN INDIVIDUAL
CORPORATION OR PARTNERSHIP, OR IF DEBT RELATED

:courts.gov/bnkrpctystats/statistics.htm#fiscal (last visited Oct. 20, 2009)

TABLE F-2 U.S. BANKRUPTCY COURTS
BUSINESS AND NONBUSINESS BANKRUPTCY CASES COMMENCED, BY CHAPT
DURING THE TWELVE MONTH PERIOD ENDED SEP. 30,

CIRCUIT AND DISTRICT	TOTAL FILINGS	PREDOMINANT NATURE OF DEBT(1) CHAP. 7	CHAP. 11	CHAP. 12	CHAP. 13	TOTAL BUSINESS FILINGS	CHAP. 7	CHAP. 11
TOTAL...	1,042,993	679,982	8,799	332	353,828	38,651	26,578	7,962
DC.....	863	434	34	-	395	47	16	29
1ST...	34,676	21,884	313	35	12,443	1,324	813	278
ME.....	2,800	2,273	17	8	502	173	135	16
MA.....	15,636	11,525	149	4	3,957	340	189	130
NH.....	3,676	2,775	27	1	873	351	262	23
RI.....	3,919	3,210	11	-	698	132	109	11
PR.....	8,645	2,101	109	22	6,413	328	118	98
2ND...	53,974	39,750	877	15	13,315	2,127	1,101	830
CT.....	7,706	5,794	146	2	1,764	397	245	135
NY,N....	10,911	7,839	40	6	3,023	248	144	38
NY,E....	15,552	11,665	146	-	3,741	423	273	128
NY,S....	9,537	7,163	496	-	1,869	741	226	482
NY,W....	9,113	6,435	47	5	2,621	272	182	46
VT.....	1,155	854	2	2	297	46	31	1
3RD...	59,846	38,931	1,236	10	19,655	2,876	1,428	1,185
DE.....	2,827	1,379	603	1	830	729	101	603
NJ.....	24,764	16,523	334	-	7,907	993	625	301
PA,E....	11,023	6,385	95	1	4,542	372	234	90
PA,M....	8,480	5,624	55	2	2,799	259	144	54
PA,W....	12,737	9,010	147	6	3,574	519	322	135
VI.....	15	10	2	-	3	4	2	2
4TH...	77,978	44,715	710	20	32,533	2,682	1,856	574
MD.....	16,926	10,302	228	1	6,395	525	318	165
NC,E....	8,956	3,374	117	7	5,458	334	192	104
NC,M....	6,264	2,995	22	2	3,245	280	203	22
NC,W....	6,386	3,841	52	2	2,491	247	176	46
SC.....	7,988	2,922	69	-	4,997	222	151	51
VA,E....	19,529	12,247	140	2	7,140	698	545	114
VA,W....	6,852	4,511	46	5	2,290	201	138	43
WV,N....	1,994	1,770	10	1	213	88	76	7
WV,S....	3,083	2,753	26	-	304	87	57	22
5TH...	70,989	31,435	796	30	38,728	3,825	2,448	755
LA,E....	3,208	1,564	57	-	1,587	182	112	56
LA,M....	1,863	936	13	-	914	58	44	12
LA,W....	10,341	2,921	33	8	7,379	370	151	33

MS,N....	5,467	2,643	48	1	2,775	159	86	48
MS,S....	6,349	2,919	32	3	3,395	172	116	31
TX,N....	15,343	6,687	228	5	8,423	1,081	730	220
TX,E....	6,288	3,283	68	6	2,931	487	359	66
TX,S....	12,053	5,294	225	5	6,529	764	480	203
TX,W....	10,077	5,188	92	2	4,795	552	370	86
6TH...	173,601	113,256	691	36	59,614	4,255	3,148	642
KY,E....	9,684	7,189	29	2	2,464	266	210	29
KY,W....	10,752	7,838	41	3	2,870	205	147	40
MI,E....	41,227	30,778	177	10	10,262	1,081	845	170
MI,W....	12,113	10,269	54	6	1,784	489	403	50
OH,N....	29,060	21,360	76	3	7,621	709	531	68
OH,S....	25,578	16,682	124	3	8,765	746	504	122
TN,E....	14,923	8,609	47	7	6,260	261	184	44
TN,M....	11,556	5,889	102	2	5,563	324	215	81
TN,W....	18,708	4,642	41	-	14,025	174	109	38
7TH...	110,443	77,879	401	36	32,125	2,722	2,136	360
IL,N....	38,133	25,818	179	1	12,133	1,040	844	163
IL,C....	8,776	6,822	16	6	1,932	170	135	15
IL,S....	5,701	3,141	21	3	2,536	142	97	16
IN,N....	14,041	10,503	41	6	3,491	284	219	34
IN,S....	23,497	15,922	80	5	7,490	497	380	72
WI,E....	13,706	10,053	21	8	3,624	342	278	21
WI,W....	6,589	5,620	43	7	919	247	183	39
8TH...	70,254	50,729	228	43	19,252	2,540	2,049	219
AR,E....	8,085	3,968	12	5	4,099	188	140	10
AR,W....	5,156	2,918	33	4	2,200	266	180	32
IA,N....	2,808	2,659	3	1	145	136	128	3
IA,S....	5,010	4,463	8	2	537	162	149	8
MN.....	15,556	12,930	46	8	2,572	756	669	45
MO,E....	12,012	7,821	43	4	4,144	317	249	40
MO,W....	12,407	8,947	50	4	3,406	314	235	50
NE.....	6,431	4,590	28	11	1,802	245	173	26
ND.....	1,330	1,185	4	3	138	60	49	4
SD.....	1,459	1,248	1	1	209	96	77	1
9TH...	191,595	143,123	1,908	38	46,518	8,288	5,919	1,600
AK.....	851	712	11	1	127	80	63	11
AZ.....	16,908	13,274	349	5	3,280	852	528	302
CA,N....	18,965	12,430	260	-	6,275	968	652	171
CA,E....	28,613	22,860	131	5	5,616	1,075	811	113
CA,C....	57,145	42,635	717	2	13,787	3,093	2,293	620
CA,S....	12,256	10,210	58	-	1,988	476	404	50
HI.....	1,810	1,391	17	1	401	67	46	13
ID.....	4,740	3,913	23	8	796	186	136	18
MT.....	1,894	1,565	10	5	314	81	66	7
NV.....	16,756	11,264	166	1	5,324	436	262	157
OR.....	11,615	8,552	41	4	3,018	339	230	36
WA,E....	5,170	3,984	14	5	1,167	170	125	12
WA,W....	14,730	10,204	111	1	4,412	462	300	90
GUAM....	128	115	-	-	13	2	2	-
NMI.....	14	14	-	-	-	1	1	-
10TH..	52,249	40,216	268	32	11,732	2,090	1,662	249

CO.....	19,692	16,779	91	3	2,818	842	722	87
KS.....	8,642	5,814	31	13	2,784	248	169	30
NM.....	4,268	3,826	33	1	408	197	149	27
OK,N....	3,036	2,652	13	-	371	140	124	9
OK,E....	1,694	1,437	6	2	249	56	47	5
OK,W....	5,740	4,185	20	11	1,524	216	172	19
UT.....	8,403	4,880	63	-	3,460	340	245	61
WY.....	774	643	11	2	118	51	34	11
11TH..	146,525	77,630	1,337	37	67,518	5,875	4,002	1,241
AL,N....	16,115	7,003	95	4	9,013	289	190	81
AL,M....	6,408	1,822	26	4	4,556	124	80	24
AL,S....	5,049	1,379	30	1	3,639	69	29	28
FL,N....	3,808	3,009	40	1	758	193	141	39
FL,M....	38,725	25,432	425	3	12,863	1,968	1,418	393
FL,S....	18,562	13,424	323	5	4,809	1,314	917	307
GA,N....	37,839	19,718	318	3	17,800	1,499	975	291
GA,M....	10,707	3,920	41	13	6,733	274	173	40
GA,S....	9,312	1,923	39	3	7,347	145	79	38

NOTE: THESE FIGURES INCLUDE THE FOLLOWING CASES NOT REFLECTED ELSEWHERE:

CHAPTER 9	AR,E.... = 001	AR,W.... = 001	CA,E.... = 001
	CA,C.... = 001		
CHAPTER 15	MA..... = 001	NY,N.... = 003	NY,S.... = 009
	NY,W.... = 005	DE..... = 014	OH,S.... = 004
	IL,N.... = 002	CA,C.... = 003	NV..... = 001
	WA,W.... = 002	CO..... = 001	FL,M.... = 002
	FL,S.... = 001		

CHAPTER 15 WAS ADDED AND SECTION 304 WAS TERMINATED BY CHANGES IN THE BANKRU
(1) SECTION 101 OF THE U.S. BANKRUPTCY CODE DEFINES CONSUMER (NONBUSINESS) I
PRIMARILY FOR A PERSONAL, FAMILY, OR HOUSEHOLD PURPOSE. IF THE DEBTOR IS A
TO OPERATION OF A BUSINESS PREDOMINATES, THE NATURE OF THE DEBT IS BUSINESS.

source: Administrative Office of the U.S. Courts, Bankruptcy Statistics, http://www.us

'ER OF THE BANKRUPTCY CODE,
2008

PREDOMINANT NATURE OF DEBT(1)					
CHAP. 12	CHAP. 13	TOTAL NON-BUSINESS FILINGS	CHAP. 7	CHAP. 11	CHAP. 13
332	3,727	1,004,342	653,404	837	350,101
-	2	816	418	5	393
35	197	33,352	21,071	35	12,246
8	14	2,627	2,138	1	488
4	16	15,296	11,336	19	3,941
1	65	3,325	2,513	4	808
-	12	3,787	3,101	-	686
22	90	8,317	1,983	11	6,323
15	164	51,847	38,649	47	13,151
2	15	7,309	5,549	11	1,749
6	57	10,663	7,695	2	2,966
-	22	15,129	11,392	18	3,719
-	24	8,796	6,937	14	1,845
5	34	8,841	6,253	1	2,587
2	12	1,109	823	1	285
10	239	56,970	37,503	51	19,416
1	10	2,098	1,278	-	820
-	67	23,771	15,898	33	7,840
1	47	10,651	6,151	5	4,495
2	59	8,221	5,480	1	2,740
6	56	12,218	8,688	12	3,518
-	-	11	8	-	3
20	232	75,296	42,859	136	32,301
1	41	16,401	9,984	63	6,354
7	31	8,622	3,182	13	5,427
2	53	5,984	2,792	-	3,192
2	23	6,139	3,665	6	2,468
-	20	7,766	2,771	18	4,977
2	37	18,831	11,702	26	7,103
5	15	6,651	4,373	3	2,275
1	4	1,906	1,694	3	209
-	8	2,996	2,696	4	296
30	592	67,164	28,987	41	38,136
-	14	3,026	1,452	1	1,573
-	2	1,805	892	1	912
8	178	9,971	2,770	-	7,201

1	24	5,308	2,557	-	2,751
3	22	6,177	2,803	1	3,373
5	126	14,262	5,957	8	8,297
6	56	5,801	2,924	2	2,875
5	76	11,289	4,814	22	6,453
2	94	9,525	4,818	6	4,701
36	425	169,346	110,108	49	59,189
2	25	9,418	6,979	-	2,439
3	15	10,547	7,691	1	2,855
10	56	40,146	29,933	7	10,206
6	30	11,624	9,866	4	1,754
3	107	28,351	20,829	8	7,514
3	113	24,832	16,178	2	8,652
7	26	14,662	8,425	3	6,234
2	26	11,232	5,674	21	5,537
-	27	18,534	4,533	3	13,998
36	188	107,721	75,743	41	31,937
1	30	37,093	24,974	16	12,103
6	14	8,606	6,687	1	1,918
3	26	5,559	3,044	5	2,510
6	25	13,757	10,284	7	3,466
5	40	23,000	15,542	8	7,450
8	35	13,364	9,775	-	3,589
7	18	6,342	5,437	4	901
43	227	67,714	48,680	9	19,025
5	32	7,897	3,828	2	4,067
4	49	4,890	2,738	1	2,151
1	4	2,672	2,531	-	141
2	3	4,848	4,314	-	534
8	34	14,800	12,261	1	2,538
4	24	11,695	7,572	3	4,120
4	25	12,093	8,712	-	3,381
11	35	6,186	4,417	2	1,767
3	4	1,270	1,136	-	134
1	17	1,363	1,171	-	192
38	723	183,307	137,204	308	45,795
1	5	771	649	-	122
5	17	16,056	12,746	47	3,263
-	145	17,997	11,778	89	6,130
5	145	27,538	22,049	18	5,471
2	174	54,052	40,342	97	13,613
-	22	11,780	9,806	8	1,966
1	7	1,743	1,345	4	394
8	24	4,554	3,777	5	772
5	3	1,813	1,499	3	311
1	15	16,320	11,002	9	5,309
4	69	11,276	8,322	5	2,949
5	28	5,000	3,859	2	1,139
1	69	14,268	9,904	21	4,343
-	-	126	113	-	13
-	-	13	13	-	-
32	146	50,159	38,554	19	11,586

3	29	18,850	16,057	4	2,789
13	36	8,394	5,645	1	2,748
1	20	4,071	3,677	6	388
-	7	2,896	2,528	4	364
2	2	1,638	1,390	1	247
11	14	5,524	4,013	1	1,510
-	34	8,063	4,635	2	3,426
2	4	723	609	-	114
37	592	140,650	73,628	96	66,926
4	14	15,826	6,813	14	8,999
4	16	6,284	1,742	2	4,540
1	11	4,980	1,350	2	3,628
1	12	3,615	2,868	1	746
3	152	36,757	24,014	32	12,711
5	84	17,248	12,507	16	4,725
3	230	36,340	18,743	27	17,570
13	48	10,433	3,747	1	6,685
3	25	9,167	1,844	1	7,322

)PTCY LAWS EFFECTIVE OCTOBER 17, 2005.
)EBT AS THAT INCURRED BY AN INDIVIDUAL
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:courts.gov/bnkrpctystats/statistics.htm#fiscal (last visited Oct. 20, 2009)

Is Obtaining Credit Counseling for Bankruptcy Difficult?

Busting the Myth of Bankruptcy Debtor Education

By **Sophie Walton**

When the Bankruptcy Code was revamped in 2005 with The Bankruptcy Abuse Prevention and Consumer Protection Act, Congress added a provision that required consumers to participate in debtor education classes prior to filing bankruptcy. These classes were designed to accomplish several goals and initially frightened many individuals into rushing to file their bankruptcy petitions prior to the effective date of the law. Consumers and bankruptcy attorneys alike flooded the Bankruptcy Courts with thousands of petitions for bankruptcy relief to avoid this debtor education. It was feared that this new requirement was cumbersome and would over-burden the consumer who was desperate for bankruptcy relief. Many consumers even misunderstood and believed that they could not file bankruptcy or that the process was now so difficult they should not even attempt to file for bankruptcy relief. I am aware of this because I am a paralegal who works within this field and put in countless hours of overtime during the mad dash to file in the fall of 2005.

Even though filings did drop after the law went into affect, the 2005 legislation did not cause bankruptcy filings to stop completely. Moreover, the rumors about debtor education courses and classes being difficult, time consuming and over-burdensome are not true. Our clients have had no trouble obtaining their debtor education certifications and in fact, have commented that the process is not as difficult or time consuming as they had initially anticipated.

There are two steps that debtors must complete with regard to debtor education and credit counseling in order to file for bankruptcy relief and receive their bankruptcy discharge. (There may be limited and specific instances where these requirements are waived or modified and you should seek the advice of a bankruptcy attorney to determine if you qualify.) The first is your Credit Counseling Certificate - - debtors must have this certificate to file with their bankruptcy petition. Only agencies that have been certified by the Office of the U. S. Trustee are eligible to issue certificates accepted by the court. A list of Approved Credit Counseling Agencies is on the website for the U.S. Trustee Program. Each agency must disclose all fees up front but many of them offer online and telephone counseling to make the process quick and easy.

The second requirement is that debtors complete Debtor Education (personal financial management instruction course) prior to receiving a bankruptcy discharge. There are deadlines for completing this course that your attorney will review with you. These agencies provide courses in financial education and a certificate of completion that is then filed with the Bankruptcy Court. A list of the approved agencies for debtor education may be found on the website for the U.S. Trustee Program.

It is a myth that people cannot file for bankruptcy relief and that debtor education is too much of a hassle to be worth the trouble. The fact is that bankruptcy relief is available to debtors and debtor education has not hampered that relief.

NOTE: Information contained in this article is NOT legal advice and should not be relied upon as legal advice. This article was not written by an attorney. You should seek the advice of an attorney if you are contemplating bankruptcy.

The Washington Times

Thursday, July 26, 2007

"Junk social science index"

No one ever accused Congress of being overly meticulous about the scientific evidence it takes in. But the 110th Congress has been on a binge diet of junk social science. It's no wonder it's been looking sick lately.

Or should we say "sicko?" An excellent example is last week's hearing before the House Subcommittee on Commercial and Administrative Law. Preciously titled "Working Families in Medical Crisis: Medical Debt and Bankruptcy," the hearing purported to be a serious look at medical debt and bankruptcy. In reality, it was just another arm of the publicity leviathan behind Michael Moore's new "documentary" titled "Sicko."

The star witness was Donna Smith, whose story was featured in the movie — including her trip to Havana to seek the supposedly superior medical treatment available in Cuba. She was surrounded at the hearing by a bevy of nurses in brightly colored "Sicko" T-shirts, who applauded her testimony enthusiastically. The hearing quickly developed into a cheerleading session for single-payer health care — over which the subcommittee has no jurisdiction.

But Miss Smith's testimony was the best — or the least bad — part of the hearing. At least she had a story to tell, which she told forcefully and, as far as we could determine, forthrightly. Most policymakers can discern the difference between a serious inquiry into bankruptcy policy and a single-anecdote photo opportunity, so there is little danger bankruptcy policy will be crafted in a way that responds only to Miss Smith's case.

The same cannot be said of the testimony of Harvard Professors David Himmelstein and Elizabeth Warren, purported to be generally applicable social science. In fact, it was junk. Blandly entitled "Illness and Injury as Contributors to Bankruptcy," their long-discredited 2005 study may be one of the most misleading pieces of research ever placed before Congress — no small dishonor.

The study's central findings were that 54½ percent of all bankruptcies have a "medical cause" and 46.2 percent of all bankruptcies have a "major medical cause." Even if this were true, bankruptcy law already provides adequate safeguards for the special problems posed by medical bankruptcies, as one of us (Mr. Zywicki) testified at the hearing. But it is not true. And the only way to make such a claim is to gerrymander the definition of medical bankruptcies to generate the desired results — true junk social science.

For example, the study classifies uncontrolled gambling, drug or alcohol addiction, and the birth or adoption of a child as "a medical cause." There are indeed situations in which a researcher may legitimately classify those conditions as "medical," but a study used to prove Americans are going bankrupt as a result of crushing medical debt is not one of them.

A father who has gambled away his family's mortgage payment is not the victim of crushing medical bills. Similarly, new parents who find they can no longer afford their previous lifestyle now that one of them has to stay home with the baby will usually find the obstetrician's bill the least of their problems. Babies are a financial hardship even when hospitals give them away free.

But that's just the tip of the iceberg. The authors also classified bankruptcies as having a "major medical cause" if the debtors had more than $1,000 in accumulated, out-of-pocket medical expenses (uncovered by insurance) over the course of the two years prior to the bankruptcy, even if the debtors did not cite illness or injury as among the reasons for their bankruptcy.

Nobody likes to have to pay $1,000 in medical expenses, even if it is spread out over two years. But for most Americans (particularly those with enough at stake to declare bankruptcy), it is not catastrophic.

To put this figure in perspective, in 2001 (the year that was the basis for the study's sample) average per capita out-of-pocket medical expenses were $683 — meaning during that two-year period the average American spent about 30 percent more than their figure on uncovered medical expenses.

To designate all cases involving expenses of more than $1,000, regardless of circumstances, as bankruptcies with a "major medical cause" is both silly and deliberately misleading. A bankruptcy with $1,001 in uncovered medical expenses and $50,000 on a Bloomingdale's card would constitute a "medical bankruptcy" in their study. Perhaps their expansive definition of "medical bankruptcy" should include self-proclaimed "shopaholics" as well.

We could go on. The point is simply that the study uses trick after trick to classify as many bankruptcies as possible as medical. It's remarkable they didn't include them all.

What do the real data show? Numerous studies have found the number of bankruptcies caused by medical debt to be dramatically lower than Mr. Himmelstein and Miss Warren report — down in the single digits.

Among the most recent is a study of 5,203 bankruptcy filers (about threefold the number examined by Mr. Himmelstein and Miss Warren) by the Executive Office of the United States Trustee. It found 54 percent of filers listed no medical debt at all and that medical debt accounted for about 5½ percent of the total general unsecured debt. About 90.1 percent of filers reported no medical debt or medical debt of less than $5,000. Of the 46 percent who reported medical debt, 78 percent reported medical debt below $5,000, with an average of only $1,212 within that group — hardly enough to send the average family into bankruptcy. Overall, 1 percent of the cases accounted for a total of 36½ percent of medical debt, and less than 10 percent of all cases represent 80 percent of all medical debt.

In short, in a tiny number of cases, substantial medical debt does force bankruptcy. In a few others, medical debt combines with otherwise high levels of mortgage, automobile or credit card debt to tip someone into bankruptcy. But the notion that half of bankruptcies are driven by medical debt is unsupported and insupportable.

Why did a congressional subcommittee turn to such a thoroughly discreditable study when it needed information on medical debt and bankruptcies? We can only speculate. But the idea Congress would consider revamping the bankruptcy law — or worse yet, the entire health-care system — on the basis of junk social science is enough to make us feel sick.

Todd J. Zywicki and Gail Heriot are professors of law at George Mason University and the University of San Diego respectively.

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

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[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.

Bankruptcy and Consumer Behavior: Theory and Evidence from the U.S.[1]

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[1] I am grateful to Charles Grant and Giuseppe Bertola for helpful comments and to the Economics Program at NSF for research support under grant number 0212444.

Introduction. This paper surveys theoretical research on personal bankruptcy, presents a model of optimal bankruptcy policy, discusses U.S. bankruptcy law, and surveys empirical evidence from the U.S. concerning how bankruptcy affects credit markets and other consumer behaviors. Bankruptcy law is an important factor affecting consumer credit markets, because whether consumers repay their loans or default depends on whether the legal system punishes defaulters and, if so, how severely. Bankruptcy law also affects other aspects of consumer behavior, including the decision to file for bankruptcy, the decision to become an entrepreneur, the number of hours worked, and how consumers allocate their portfolios.

Unlike most of the European countries, the U.S. has separate bankruptcy laws for consumer debtors versus for corporations. The U.S. bankruptcy system is also unusual in how favorably its personal bankruptcy law treats debtors and how frequently consumers default and file for bankruptcy. U.S. consumers held about $1,720 billion in unsecured debt in 2002, or about $16,000 per household. The annual loss rate to creditors is about 7%, suggesting that losses on unsecured debt are about $120 billion per year or $1,100 per household per year.[2] The number of personal bankruptcy filings per year in the U.S. increased five-fold between 1980 and 2003, from 300,000 filings to more than 1,500,000 (see table 1). This means that nearly one and a half percent of U.S. households currently files for bankruptcy each year. Despite the increase in filing rates and the high rate of default on consumer loans, the proportion of U.S. households that would benefit financially from filing for bankruptcy is even higher than the proportion of households that currently files. Between 15% and 33% of households would benefit financially from filing for bankruptcy, depending on whether households take advantage of strategies that increase their financial benefit from filing, such as converting assets from non-exempt to exempt categories or moving to high exemption states.[3]

The paper is arranged as follows. Section I discusses the economic objectives of bankruptcy law generally and examines how the objectives of corporate and personal bankruptcy differ. Section II discusses U.S. personal bankruptcy law. Section III presents a model of optimal personal bankruptcy policy. Section IV discusses other theoretical issues related to personal bankruptcy. Sections V-X survey empirical research on the effects of personal bankruptcy law on credit

[2] See table 1 for the source of data on number of bankruptcy filings. Data on consumer debt are taken from *Economic Report of the President*, 2003, and "Effect of U.S. Economy on Credit Card Loss Rates," *S&P Business Wire*, Dec. 18, 2002.

[3] White (1998a).

markets, the decision to file for bankruptcy, and other aspects of consumer behavior. Section XI concludes.

I. Objectives of Bankruptcy Law.

Bankruptcy law applies to corporations, unincorporated businesses, and consumers. Economists have discussed five separate objectives of bankruptcy: (1) encouraging efficient investment decisions before and after bankruptcy, (2) encouraging efficient effort-level decisions before and after bankruptcy, (3) avoiding a race by creditors to be first that could cause businesses to shut down prematurely, (4) making an efficient choice between liquidation and reorganization once debtors are in bankruptcy, and (5) providing debtors with insurance against the consequences of adverse shocks to consumption, such as those caused by illness, job loss, or failure of the debtor's business.

Consider which of these objectives apply to personal bankruptcy. Note that personal bankruptcy law covers both consumer and small business bankruptcy, since most small businesses are unincorporated and therefore business debts are legal obligations of the business owner.

Objective (1) does not apply to consumer debtors, because consumers generally borrow to finance consumption rather than investment. But it does apply to small business. Objective (2) applies mainly to consumer debtors. Outside of bankruptcy, consumer debtors are obliged to use part of both their earnings and their wealth to repay debt and, if they default, creditors can collect by garnishing wages and/or claiming debtors' assets. After filing for bankruptcy, debtors may also be obliged to use their earnings and wealth to repay pre-bankruptcy debt. In both situations, the obligation to repay can discourage debtors from working hard. But under U.S. law, filing for bankruptcy ends debtors' obligation to use any of their earnings to repay debt. The Supreme Court has justified this policy—called the "fresh start"--on the grounds that it encourages debtors to work hard after bankruptcy ("from the viewpoint of the wage earner, there is little difference between not earning at all and earning wholly for a creditor").[4] A similar justification for the fresh start also applies to owners of small businesses, since their incentive to start new businesses and their ability to borrow after bankruptcy are higher if they are not required to use future profits to repay pre-

[4] Local Loan Co. v. Hunt, 202 U.S. 234 (1934).

bankruptcy business debts.[5] However the fresh start also encourages opportunism, since it gives debtors incentives to borrow more and work less before bankruptcy, and to file for bankruptcy even when they are not in financial distress.

In contrast, objectives (3) and (4) are mainly relevant in the corporate bankruptcy context. These objectives arise because failing firms may either liquidate or continue to operate (reorganize) in bankruptcy and inefficiencies occur when firms take the wrong path. A cost of creditors' racing to be first to collect is that it may cause corporations to liquidate when it would be more economically efficient for them to reorganize.[6] But in personal bankruptcy, true liquidation no longer occurs. This is because, while individual debtors' most valuable asset is generally their human capital, human capital can only be liquidated by selling debtors into slavery--as the Roman did--or confining them in debtors' prisons until someone else pays their debts--as the British did in Charles Dickens' time. Since slavery and debtors' prisons are no longer used, all personal bankruptcies are reorganizations. Bankrupt debtors retain ownership of their human capital and the right to continue using it, but some of their financial wealth/non-human capital may be liquidated and they may face a tax on the post-bankruptcy return to their human capital. (Nonetheless, one of the two U.S. personal bankruptcy procedures is called liquidation.)

Finally, objective (5) applies mainly in personal bankruptcy. This is the objective of insuring debtors against the consequences of adverse shocks to consumption, such as those caused by illness, job loss, or failure of the debtor's business. When earnings or wealth turns out to be low, the obligation to repay debt makes a bad situation worse for debtors and may cause their consumption to fall to very low levels. But very low consumption levels can be costly even if they are temporary, because debtors may lose their homes, develop permanent health problems because they cannot afford medical care to treat their illnesses, their children may drop out of school and not go back, etc. Sharp reductions in consumption by a large number of households may also cause or contribute to an economy-wide recession. Individual debtors can partially insure themselves against adverse consumption shocks by limiting their borrowing and diversifying their financial wealth. But they remain vulnerable since they cannot diversify their human capital, which for most

[5] Other countries do not generally apply the fresh start in bankruptcy and they treat debtors much more harshly. For example, in Germany, individual debtors are not allowed to file for bankruptcy voluntarily and their debts are not discharged in bankruptcy, although creditors' efforts to collect are stayed. Debtors are required to repay from future earnings. See White (1996)) and Alexopoulos and Domowitz (1998) for discussion. Note that in the U.S., not all debt is discharged in bankruptcy, so that in practice debtors receive only a partial fresh start.

[6] See White (1994) for a model of objectives (3) and (4).

debtors constitutes most of their wealth. Personal bankruptcy provides partial consumption insurance to debtors by discharging some debts when adverse shocks occur, thereby freeing funds for consumption that would otherwise be used for debt repayment.[7]

Exemptions in personal bankruptcy are closely related to the insurance objective. When individual debtors file for bankruptcy, they are allowed to retain ownership of all their financial wealth up to the exemption level, plus their human capital. Higher wealth exemptions increase the level of insurance, because when the wealth exemption is higher, debtors file for bankruptcy and obtain debt relief in response to smaller adverse shocks to income or wealth. The 100% exemption for future wages—the "fresh start"—also provides insurance since debtors keep all of their post-bankruptcy wages in situations where adverse shocks cause them to file for bankruptcy.

Exemptions also provide insurance to owners of non-corporate small businesses, since owners of failed firms can file for bankruptcy and obtain discharge of both the firm's debts and their own personal debts. In bankruptcy they must use all of their non-exempt wealth to pay the firm's debts, but they keep their exempt wealth plus all of their post-bankruptcy earnings. Note that bankruptcy law provides owners of non-corporate firms with far less protection than that provided to corporate shareholders through the corporate form and limited liability, since corporate shareholders' liability for the corporation's losses is limited to loss of the value of their shares. In addition, corporate shareholders can further insure themselves by diversifying their shareholdings.

II. U.S. Personal Bankruptcy Law

In the U.S., the Constitution reserves for the Federal government the power to make laws concerning bankruptcy. This means that—with one important exception—personal bankruptcy law is uniform across the U.S. When a debtor files for bankruptcy, creditors must cease their collection efforts and cease garnishing the debtor's wages.[8]

There are two different personal bankruptcy procedures and debtors are allowed to choose between them. The first procedure is called Chapter 7 and, under it, all unsecured debts are discharged. Unsecured debts are those for which the creditor does not have a claim on any

[7] Rea (1984) and Jackson (1986) were the first to discuss the insurance aspect of personal bankruptcy. See Olson (1999) and Athreya (2002) for discussion in the macroeconomic context.

[8] To garnish wages, creditors must obtain a court order allowing them to collect a portion of the debtor's wages from the debtor's employer. Federal law allows creditors to garnish up to 25% of debtors' wages, but some states restrict garnishment further and a few prohibit it completely.

particular asset owned by the debtor; they include credit card debt, installment debt, medical bills, and tort judgments. (Secured debts—such as mortgage and car loans—are not discharged in bankruptcy unless the debtor gives up the asset that secures the debt.) Debtors must give up all of their non-exempt assets for repayment to creditors, but—under the "fresh start"--all of their future earnings are exempt from the obligation to repay. In 1978, the U.S. Congress adopted a uniform set of bankruptcy exemptions, but gave the states the right to opt out and adopt their own exemptions. About two-thirds of the states opted out by requiring that their residents use the state's exemptions in bankruptcy. The remaining one-third adopted their own exemptions, but allowed residents to choose between the states' exemptions and the Federal exemption. As a result, exemption levels are the only feature of bankruptcy law that varies across the states.[9]

Table 1 gives information on bankruptcy exemptions by U.S. state as of 2001. The top panel gives exemptions for home equity ("homestead" exemptions), which vary widely. Texas, Florida, and five other states have unlimited exemptions for wealth in the form of home equity, which means that wealthy debtors in these states can file for bankruptcy and keep millions of dollars in wealth as long as it is invested in their homes. In contrast, Delaware and Maryland have no exemption at all for home equity. Some states allow married couples who file for bankruptcy to double the homestead exemption and a few allow the elderly to take larger exemptions. The middle panel of table 1 gives exemptions for personal property. Exemptions for personal property may be specified either as maximum dollar values or as blanket exemptions for particular types of property. Most states have separate exemptions for clothing, equity in cars, furniture, jewelry, tools of the trade, and burial plots. Some states also have "wildcard" exemptions that apply to any type of property. The personal property exemptions listed in table 1 are the sum of non-housing exemptions for which states specify a maximum dollar value. In addition to these exemptions, some states have exemptions for retirement accounts and life insurance policies. The bottom panel of table 1 lists states that allow their debtors to choose between the state's exemptions and the Federal exemption. Compared to most state exemptions, the Federal exemptions favor renters relative to homeowners, since the Federal personal property exemptions are relatively high and renters can apply part of the Federal homestead exemption to personal property.

[9] See Hynes, Malani, and Posner (2003) for discussion of the political economy of exemption laws. All of the states opted out between 1978 and 1982 and, since then, relatively few changes in exemption levels have occurred.

The second personal bankruptcy procedure, called Chapter 13, is intended for wage earners. Under it, debtors in bankruptcy keep all of their assets in bankruptcy, but they must propose a multi-year plan to repay part of their unsecured debt from future earnings. If they fulfill the repayment plan, then the unpaid portion of the debt is discharged. Creditors are entitled to receive the same amount in Chapter 13 as they would receive if the debtor had filed under Chapter 7, but no more. This means that if all of a debtor's assets would be exempt under Chapter 7, the debtor can file under Chapter 13 and propose to repay only a token amount. Another reason why debtors sometimes file under Chapter 13 is that they are behind on their mortgage or car payments and filing under Chapter 13 delays the foreclosure process. In Chapter 13, car lenders can be forced to reduce the principle value of the loan to the car's current market value and mortgage lenders sometimes voluntarily agree to easier repayment terms.

Because debtors have the right to choose between Chapters 7 and 13, filing for bankruptcy is very favorable for them. Debtors can choose between using part of their future earnings but none of their wealth to repay debt under Chapter 13 or using part of their wealth but none of their future earnings to repay debt under Chapter 7. This means that although both wealth and future earnings are part of debtors' ability to repay, debtors are only obliged to use one or the other to repay in bankruptcy. Because most debtors have no non-exempt wealth, they usually prefer to file under Chapter 7. In addition, debtors who have wealth that is non-exempt can often transfer it from non-exempt to exempt categories before filing for bankruptcy (such as by converting cash into home equity if their home equity is less than the homestead exemption). This allows them to file under Chapter 7 and avoid using either their future earnings or their wealth to repay their debt. About 70% of all bankruptcy filings occur under Chapter 7.[10]

III. Theory

In this section I examine a model of optimal personal bankruptcy policy that emphasizes objectives (1), (2) and (5) above.[11] I assume that individual debtors have no non-bankruptcy sources of consumption insurance, such as unemployment compensation or welfare. I also assume that there is only a single personal bankruptcy procedure, but the procedure incorporates variable

[10] For a more detailed discussion of the differences between Chapters 7 and 13 and special circumstances that might lead debtors to file under Chapter 13, see White (1998a).

[11] This section draws on Bebchuk and White (2004) and Fan and White (2003). For other models of bankruptcy that emphasize its macroeconomic effects, see Dombwitz and Alexopoulos (1998) and Athreya (2002).

exemptions for both financial wealth and future wages. (In contrast, current U.S. personal bankruptcy law either exempts all future wages under Chapter 7 or exempts all financial wealth under Chapter 13.)

The model has two periods. In period 1, a representative consumer borrows an amount B at interest rate r, to be repaid in period 2. The loan can be used either for consumption or investment—including an investment in an unincorporated business. Assume that the debt is unsecured and that it is the consumer's only loan.[12] The consumer also chooses her work hours in period 1, denoted N_1. Work hours are assumed to represent the consumer's effort level and/or investment in human capital. The wage rate per unit of time is assumed to be one. The consumer's wealth in period 1, W_1, is known with certainty.

At the beginning of period 2, the consumer chooses her period 2 labor supply, N_2. The wage rate per unit of time remains one. After making this choice, the consumer's period 2 wealth is determined by a draw from the wealth distribution, $f(W_2)$, where W_2 can take any real value. Finally the consumer decides whether to file for bankruptcy.

The rules of bankruptcy are as follows. There is a fixed dollar cost of filing, denoted F, that includes lawyers' fees and court filing fees. In bankruptcy, the debt $B(1+r)$ is discharged. There are two exemptions in bankruptcy, one for wealth and one for period 2 earnings. The wealth exemption X is assumed to be a fixed dollar amount that combines states' exemptions for homesteads and personal property. It can take any positive or negative value. The earnings exemption could either be a fraction of period 2 wages (a "bankruptcy tax") or a fixed dollar amount. But if the exemption were a fixed dollar amount, then consumers would either be subject to no bankruptcy tax at all—if their earnings were below the exemption, or would be subject to a 100% marginal bankruptcy tax on all of their earnings above the exemption. The latter situation would be extremely inefficient and would lead consumers who file for bankruptcy to reduce their earnings to the exemption level, which might involve quitting their jobs.[13] For this reason, I assume that the earnings exemption takes the form of a fixed fraction of period 2 earnings, x, where

[12] Because the consumer has only a single loan, the model does not consider priority rules in bankruptcy. See below for discussion of secured versus unsecured loans in the personal bankruptcy context.

[13] Another reason for assuming a fractional wage exemption is that wage garnishment exemptions take this form (normally 75% of wages are exempt from garnishment). Nonetheless, the proposed bankruptcy reform currently pending in the U.S. Congress imposes a fixed dollar wage exemption on certain types of debtors.

$0 \leq x \leq 1$. Consumers who file for bankruptcy must therefore repay $W_2 - X$ from their period 2 wealth plus $(1-x)N_2$ from their period 2 earnings.

Consider the relationship between discharge of debt in bankruptcy and the two exemptions. Given the absence of non-financial penalties for bankruptcy, such as slavery or imprisonment, the two exemption levels and the filing cost F determine the price of discharge. If $X = \infty$ and $x = 1$ (the maximum values for both), then the price of discharge is F. Conversely if X is large and negative and $x = 0$ (the minimum values for both), then there is no discharge of debt, i.e., the price of discharge is complete impoverishment. The "fresh start" is represented by $x = 1$. The harshest exemption policy currently allowed in the U.S. is represented by $X = 0$ and $x = 1$, where the price of discharge is $F + W_2 - X$. This is an intermediate level, since debtors must repay use all of their wealth but none of their future earnings to repay their debt. In the model, we examine how the efficiency of personal bankruptcy is affected by varying the policy parameters X and x.

Now consider the bankruptcy decision in period 2. If the consumer repays in full, period 2 consumption is $W_2 - B(1+r) + N_2$; while if she files for bankruptcy, period 2 consumption is $X + xN_2$ (assuming that she pays the bankruptcy filing cost beforehand).[14] She is assumed to make the bankruptcy decision so as to maximize her period 2 consumption. This means that the condition for bankruptcy is:

$$B(1+r) \geq (W_2 - X) + (1-x)N_2. \qquad (1)$$

Exp. (1) says that the amount of debt discharged in bankruptcy must exceed the value of non-exempt wealth and earnings that the debtor must use to repay. (1) implies that there is a threshold value of period 2 wealth, denoted $\hat{W}_2$, at which consumers are indifferent between filing or not filing, or $\hat{W}_2 = B(1+r) + X - (1-x)N_2$. Consumers file for bankruptcy if $W_2 \leq \hat{W}_2$ and do not file otherwise. Holding period 2 earnings constant, this expression implies that consumers' probability of filing for bankruptcy rises when either of the two exemptions increase.

The solid line in figure 1 graphs period 2 consumption, shown as the solid line, as a function of period 2 wealth W_2. Period 2 earnings, N_2, are assumed to be constant. Consumption has three

[14] This assumes that the consumer pays the cost of filing F beforehand, so that the cost is passed on to creditors. Also the model assumes that creditors never garnish debtors' wages, since debtors always file for bankruptcy if they default. See below for discussion of wage garnishment and the possibility that debtors might default but not file for bankruptcy.

regions: the right-most where $W_2 > \hat{W}_2$ and the debtor repays in full; the middle region where the debtor files for bankruptcy, period 2 wealth is $X \leq W_2 \leq \hat{W}_2$, and period 2 consumption is $X + xN_2$; and the left-most where the debtor files for bankruptcy, $W_2 < X$, and period 2 consumption is $W_2 + xN_2$.[15] The dashed line in figure 1 shows how the bankruptcy decision changes when period 2 labor supply increases.

Bankruptcy provides consumption insurance by shifting resources from higher to lower wealth states. Allowing consumers to file for bankruptcy and obtain debt discharge causes interest rates to rise and lowers consumption in the non-bankruptcy region, but increases consumption in bankruptcy. Higher levels of either exemption increase the amount of insurance by shifting the bankruptcy threshold $\hat{W}_2$ to the right, so that consumers file for bankruptcy at higher wealth levels. However while both exemptions provide consumption insurance, the insurance that each provides is slightly different. Raising the wealth exemption X transfers additional resources from good to medium draws of the wealth distribution, i.e., from the right hand to the middle region of figure 1. In contrast, raising the earnings exemption x transfers additional resources from good to both medium and bad draws of the distribution, i.e., from the right hand region to the middle and left hand regions of figure 1. This difference between the two exemptions suggests a new justification for the "fresh start"—that a higher earnings exemption provides more valuable consumption insurance than a higher wealth exemption, because the former transfers consumption to the region where it is lowest.

Now turn to lenders. Assume that there are many consumers who apply to borrow and all are identical as of period 1. Lenders are willing to lend as long as there exists an interest rate at which expected repayment covers the opportunity cost of funds, denoted ρ. The condition under which lenders expect to make zero profits is:

$$B(1+\rho) = \int_{-\infty}^{X} [(1-x)N_2 - F] f(W_2) dW_2 + \int_{X}^{\hat{W}_2} [W_2 - X + (1-x)N_2 - F] f(W_2) dW_2$$

[15] If consumers' wages are subject to garnishment in period 1 (because they have defaulted on an earlier debt), then $\hat{W}_2$ shifts to the left since an additional benefit of filing for bankruptcy is that garnishment ends. See below for further discussion of the relationship between default and bankruptcy.

$$+ \int_{\hat{W}_2}^{\infty} B(1+r) f(W_2) dW_2 \qquad (2)$$

The three terms on the right hand side represented expected repayment in each of the three regions of figure 1. Eq. (2) determines the market-clearing interest rate, r, as a function of the two exemption levels.

To determine how the interest rate varies with the exemption levels, differentiate (2) with respect to x and X. (We assume that B is fixed and that N_1 is independent of the two exemption levels.) The results are:

$$\frac{dr}{dx} = \left(\frac{N_2}{B}\right) \frac{\left[\int_{x}^{\hat{W}_2} f(W_2) dW_2 + Ff(\hat{W}_2)\right]\left[1 - \frac{(1-x)}{x}\varepsilon_x\right]}{\int_{\hat{W}_2}^{\infty} f(W_2) dW_2 - Ff(\hat{W}_2)} \qquad (3)$$

and

$$\frac{dr}{dX} = \left(\frac{1}{B}\right) \frac{\left[\int_{X}^{\hat{W}_2} f(W_2) dW_2 + Ff(\hat{W}_2)\right] - \left[\int_{x}^{\hat{W}_2} f(W_2) dW_2 + Ff(\hat{W}_2)\right]\left[\frac{N_2(1-x)}{X}\varepsilon_X\right]}{\int_{\hat{W}_2}^{\infty} f(W_2) dW_2 - Ff(\hat{W}_2)} \qquad (4)$$

where ε_x and ε_X denote the elasticities of N_2 with respect to x and X, respectively.

If $\varepsilon_x = 0$ ($\varepsilon_X = 0$), then dr/dx (dr/dX) must be positive as long as the cost of filing for bankruptcy F is not too high. Now consider the possibility that ε_x is non-zero, so that period 2 effort depends on the fraction of post-bankruptcy earnings that workers keep. Note that the expression $[1 - ((1-x)/x)\varepsilon_x]$ must be positive for any reasonable values of ε_x.[16] Therefore if ε_x shifts from zero to positive, dr/dx becomes smaller in size but remains positive. This is because the increase in the wage exemption causes consumers to work more in period 2 since the return to work effort is higher. As a result, they earn more and repay more, so that lenders raise the interest rate by less in response to the same increase in x. If ε_x shifts from zero to negative, then dr/dx

[16] For example, if $x = .5$, then ε_x must be less than 1.

becomes more positive since consumers work less and repay less when the exemption level rises. Finally, suppose ε_X is non-zero. Regardless of sign, it is likely to be small, since labor supply is not very responsive to changes in wealth.[17] dh/dX must be positive as long as both ε_X and F are small.

Eqs. (3) and (4) are not always satisfied, so that lending markets sometimes break down. When X increases, borrowers are more likely to file for bankruptcy. Lenders respond by raising the interest rate, but this only increases the amount that debtors repay if they do not file for bankruptcy. As a result, raising the interest rate becomes less and less effective as X rises. (While borrowers may also partially repay their debt in bankruptcy, the amount they repay is unaffected by the interest rate.) At very high levels of X, the probability of debtors repaying in full is so low that no interest rate clears the market and creditors cease lending. A similar argument applies to increases in x, since when x rises, debtors are more likely to file for bankruptcy and repay less when they do so. Because all potential borrowers are identical as of period 1, lenders either lend to all or stop lending completely.[18]

To illustrate, suppose $f(W_2)$ is distributed normally with a mean of 2 and standard deviation of .25 and suppose $x = 1, B = 1$, $F = 0$, $\rho = 0.1$, and $\varepsilon_X = 0$. Then loan markets operate as long as X is less than .9 (90% of the loan amount), but they fail if X exceeds .9. However if future wages are not entirely exempt, then loan markets can operate at even higher levels of X. Suppose $X = .95$ and $N_2 = 1 - .1x$, so that $\varepsilon_x = -.1x/(1 - .1x)$. Then loan markets operate as long as $x \leq .4$, but fail if $x > .4$.

Now turn to consumers. Their utility in each period is assumed to depend positively on consumption and negatively on work hours and they are assumed to be risk averse. For simplicity, the discount rate is assumed to be zero. The representative consumer's expected utility function is therefore:

[17] While the stereotype is that wealthy people work less, empirical evidence suggests that the probability of owning a business increases with wealth. See Holtz-Eakin et al (1994) and Fan and White (2003).

[18] If borrowers varied along some credit-relevant dimension that lenders could observe in period 1, then lenders would gradually cease lending to more credit-worthy borrowers as the bankruptcy exemption level increased.

$$U(W_1 + N_1 + B, N_1) + \int_{\tilde{w}_2}^{\infty} U(W_2 + xN_2, N_2) f(W_2) dW_2$$

$$+ \int_{X}^{\tilde{w}_2} U(X + xN_2, N_2) f(W_2) dW_2 + \int_{\tilde{w}_2}^{\infty} U(W_2 - B(1+r) + N_2, N_2) f(W_2) dW_2 \qquad (5)$$

Because all consumers are identical as of period 1, the social welfare function (SWF) is the same as the representative consumer's expected utility function.[19]

Individual consumers determine their period 1 and period 2 labor supply, N_1 and N_2, so as to maximize expected utility, treating the interest rate and the exemption levels as fixed. They increase N_1 until minus the ratio of the marginal disutility of effort to the marginal utility of consumption in period 1 equals unity. This means that N_1 is unaffected by the exemption variables as long as additional effort does not increase debtors' obligation to repay in bankruptcy. (This holds, for example, if consumers use all their additional wages for consumption.) Consumers increase N_2 until minus the ratio of the expected marginal disutility of effort to the expected marginal utility of consumption in period 2 equals the expected value of working an additional hour, or $(1-p(1-x))$, where p denotes the probability of bankruptcy.

Now consider the determination of the optimal bankruptcy policy, denoted by X^* and x^*. For marginal changes in the two exemption variables, the conditions for an optimal bankruptcy policy are determined by differentiating (5) with respect to x and X.[20] The resulting first order conditions are:

$$\frac{dSWF}{dX} = U_1(X + xN_2, N_2) \int_{X}^{\tilde{w}_2} f(W_2) dW_2 - [B\frac{dr}{dX}] \int_{\tilde{w}_2}^{\infty} U_1(W_2 - B(1+r) + N_2, N_2) f(W_2) dW_2 \qquad (6)$$

and

$$\frac{dSWF}{dx} = (N_2) \int_{\tilde{w}_2}^{\tilde{w}_2} U_1(\max[W_2, X] + xN_2, N_2) f(W_2) dW_2$$

$$- [B\frac{dr}{dx}] \int_{\tilde{w}_2}^{\infty} U_1(W_2 - B(1+r) + N_2, N_2) f(W_2) dW_2 \qquad (7)$$

[19] The model assumes that wages are not subject to garnishment in period 1. It could be modified to consider this possibility.

[20] The envelope theorem ensures that consumers make optimal choices of period 1 and period 2 labor supply as long as changes in the exemption variables are small.

where U_1 denotes the marginal utility of consumption. The optimal exemption levels are determined by substituting (3) and (4) into (6) and (7), respectively, setting the resulting expressions equal to zero and solving.

It is easiest to interpret special cases of (6) and (7). Suppose filing costs F are zero and $\varepsilon_X = 0$. Then (6) becomes:

$$\frac{dSWF}{dX} = \int_{X}^{\bar{W}_2} f(W_2)dW_2\Big[\, U_1(X + xN_2, N_2) - \frac{\int_{\underline{W}_2}^{\bar{W}_2} U_1(W_2 - B(1+r) + N_2, N_2) f(W_2)dW_2}{\int_{\underline{W}_2}^{\bar{W}_2} f(W_2)dW_2} \,\Big] \tag{8}$$

The term in square brackets is the marginal utility of consumption when consumers file for bankruptcy but use part of their wealth to repay (the middle region of figure 1), minus the average marginal utility of consumption when consumers avoid bankruptcy (the right hand region of figure 1). At low levels of X, the marginal utility of consumption must be higher in bankruptcy than outside of bankruptcy, so the expression must be positive. As X rises, the average marginal utility of consumption in bankruptcy falls (because wealth is higher since more wealth is exempt), while the average marginal utility of consumption outside of bankruptcy rises (because interest rates rise). So the difference between the two terms gets smaller.

Nonetheless expression (8) must remain positive, so that the optimal wealth exemption level X^* is the highest level at which lenders are willing to lend. The intuition is that risk averse consumers always want to purchase additional insurance as long as it is sold at a fair price. A higher wealth exemption provides additional consumption insurance and lenders "sell" the insurance at a fair price because of the zero profit constraint. As a result, borrowers wish to buy as much insurance as possible and the optimal wealth exemption X^* is the highest possible level.

Now suppose F is positive rather than zero. In this case, a third term whose sign is negative is added to expression (8). The additional term may either cause the optimal exemption level to fall or to remain unchanged. With $F > 0$, consumption insurance now costs consumers more than the fair price, since they pay both the fair price plus an additional cost when they file for bankruptcy. As a result, demand for consumption insurance falls and even risk averse consumers may not wish

to purchase the maximum amount. The optimal exemption level falls by more as F rises and as consumers become less risk averse.

Now consider the case when $\varepsilon_X \neq 0$ but $F = 0$. Then the following third term is added to the expression in square brackets in (8):

$$+\frac{\int_{\bar{W}_2}^{\infty} U_1(W_2 - B(1+r) + N_2, N_2) f(W_2) dW_2}{\int_{\bar{W}_2}^{\infty} f(W_2) dW_2} \left(\frac{N_2(1-x)}{X}\right)\varepsilon_X \tag{8'}$$

This term has the same sign as the sign of ε_X. Therefore if ε_X shifts from 0 to negative, then $dSWF/dX$ becomes negative at the old value of X^*. As a result, the optimal exemption level X^* becomes smaller. This is because an increase in X now causes work effort to fall, so that borrowers repay less and lenders raise interest rates by more than they did when work effort was fixed. As a result, consumption insurance is more expensive and the efficient amount of insurance falls. The opposite reasoning holds if ε_X shifts from zero to positive.

Now turn to the earnings exemption. Suppose again that $F = 0$ and $\varepsilon_x = 0$. Then substituting eq. (4) into eq. (7), the resulting expression is:

$$(N_2 \int_{-\infty}^{\bar{W}_2} f(W_2) dW_2)\left[\frac{\int_{-\infty}^{\bar{W}_2} U_1(\max[W_2, X] + xN_2, N_2) f(W_2) dW_2}{\int_{-\infty}^{\bar{W}_2} f(W_2) dW_2} - \frac{\int_{\bar{W}_2}^{\infty} U_1(W_2 - B(1+r) + N_2, N_2) f(W_2) dW_2}{\int_{\bar{W}_2}^{\infty} f(W_2) dW_2}\right] \tag{9}$$

The interpretation of expression (9) is similar to that of expression (8). The terms in square brackets in (9) are the average marginal utility of consumption in bankruptcy minus the average marginal utility of consumption outside of bankruptcy. For a given level of X, a higher earnings exemption provides consumers with additional consumption insurance. Because lenders "sell" the insurance at a fair price, risk averse consumers wish to buy as much as possible and the optimal exemption level x^* is the maximum level at which lenders are willing to lend. Additional insurance in the form of a higher earnings exemption is particularly valuable, since debtors must use part of

their period 2 earnings to repay their debt even when their wealth falls in the lowest region in figure 1. Raising x therefore raises consumption where it is the most valuable.

When F is positive rather than zero, an additional term with a negative size is added to exp (9) and the optimal earnings exemption is therefore lower. The intuition is the same as that given for the optimal wealth exemption. When ε_x is non-zero and $F = 0$, an additional term is added to expression (9) that has the same sign as the sign of ε_x. If ε_x is negative (positive), the optimal x^* falls (rises) relative to the optimal level when $\varepsilon_x = 0$. The reasoning is the same as above.

Wang and White (2000) simulated a parameterized version of this model. They assumed that the cost of filing for bankruptcy F was positive and that ε_x and ε_X were both negative. They found that the optimal earnings exemption level x^* was always one—a result that supports the U.S. "fresh start" policy. But in an extension of their model, Wang and White introduced an additional margin for moral hazard—consumers were allowed to choose whether to hide part of their non-exempt wealth when they filed for bankruptcy (in addition to choosing their effort level). Hiding a portion of wealth makes filing for bankruptcy more attractive, but drives up interest rates. In this situation, Wang and White found that the optimal wage exemption was sometimes less than 100%. A lower wage exemption improved efficiency by discouraging consumers from hiding wealth, since hiding wealth made them more likely to file for bankruptcy and therefore they paid the bankruptcy "tax" on earnings more often than consumers who did not hide wealth. (In contrast a lower wealth exemption encouraged consumers to hide wealth.) In Wang and White's model, the two exemptions were substitutes, since when the optimal wage exemption level was less than 100%, the optimal wealth exemption level increased.

What does the model imply in terms of testable hypotheses? First, it suggests that in jurisdictions with higher bankruptcy exemptions, consumption is more highly insured and therefore is more certain/less variable. Second, higher wealth exemptions reduce the supply of credit, so that interest rates are predicted to be higher and credit rationing is predicted to be stronger in jurisdictions with higher exemptions. Third, if consumers tend to be risk averse, then jurisdictions with higher exemption levels will have higher demand for credit, since consumers demand more credit when they have more consumption insurance. But if debtors are risk neutral or not very risk

averse, then higher exemption levels may reduce demand for credit, because the cost of the additional wealth insurance is more than debtors are willing to pay. Fourth, if potential entrepreneurs are risk averse, then jurisdictions that have higher bankruptcy exemptions will tend to have higher entrepreneurship rates. This is because potential entrepreneurs are more willing to take the risk of going into business if a generous bankruptcy exemption reduces the downside risk of business failure. Finally, the model suggests that the predicted change in work effort following bankruptcy is ambiguous, since the income and substitution effects pull in opposite directions.

Not all of these predictions have been tested, but in section IV I survey the empirical literature on personal bankruptcy in the U.S. The next section of the paper discusses other theoretical issues in personal bankruptcy.

IV. Additional Theoretical Considerations

Bankruptcy and incentives for strategic behavior

A problem with U.S. personal bankruptcy procedures is that they encourage debtors to engage in strategic behavior in order to increase their financial gain from filing. Using the same notation as above, consumers' financial benefit from filing for bankruptcy under Chapter 7 can be expressed as:

$$Financial\ benefit = max[B(1+r) - max[W_2 - X, 0], 0] - F \qquad (10)$$

Here the fresh start policy is assumed to be in effect, so that future earnings are exempt from the obligation to repay. Consumers' financial benefit from filing for bankruptcy is the amount of debt discharged, $B(1+r)$, minus the value of non-exempt assets that they must give up in bankruptcy, which is the $\max[W_2 - X, 0]$. (Bankruptcy costs are ignored.) Although this expression gives the financial benefit from filing under Chapter 7, it also approximates the financial benefit from filing under Chapter 13, since debtors' obligations to repay under the two Chapters are closely related.

White (1998a and 1998b) calculated the proportion of U.S. households that would benefit from filing for bankruptcy, using data from the *Survey of Consumer Finances*, which includes detailed information on households' wealth. For each household in the SCF, she calculated the financial

benefit of filing for bankruptcy on the survey date. The results were that approximately one-sixth of U.S. households had positive financial benefit and would therefore benefit from filing.

White also examined how the results would change if consumers pursued various strategies to increase their financial gain from bankruptcy, including (a) debtors converting assets from non-exempt to exempt by using them to repay part or all of their mortgages (assuming that additional home equity would be exempt in bankruptcy), (b) debtors moving to a more valuable house, if doing so would allow them to shelter additional wealth in bankruptcy, and (c) debtors charging all of their credit cards to the limit (but not obtaining new credit cards). These strategies together increased the proportion of households that benefited from bankruptcy from one-six to one-third. A final strategy involved debtors moving to Texas before filing for bankruptcy, since Texas has the most favorable exemptions. Combining all of these strategies, 61% of all U.S. households could benefit from filing for bankruptcy. These results suggest that, even with the high bankruptcy filing rate in the U.S., many more households could benefit from filing for bankruptcy than actually choose to file. Thus the bankruptcy filing rate is likely to continue to increase in the future.

Default without bankruptcy.

The model discussed above did not consider the possibility that consumer might default on their debt but not file for bankruptcy. White (1998b) investigated an asymmetric information game in which the decision to default is separate from the decision to file for bankruptcy. Debtors first decide whether to default and, following default, creditors decide whether to attempt to collect by obtaining a court order to garnish the debtor's wages. If creditors attempt to collect, then debtors choose whether to file for bankruptcy. There are two types of debtors. Type 1's are assumed to have low wealth and they always default. If creditors attempt to collect, then type 1 debtors always file for bankruptcy and creditors receive nothing. Type 2 debtors have higher wealth and they may or may not default. If creditors attempt to collect following default, type 2 debtors always repay in full. Creditors are assumed unable to identify individual debtors' types at the time of default. Attempting to collect is assumed to be costly for creditors, while filing for bankruptcy imposes a cost on debtors.

White shows that in equilibrium, type 1 debtors always default, but type 2 debtors and creditors both play mixed strategies. This means that some debtors of both types obtain the benefit of debt discharge without bearing the costs of filing for bankruptcy, because they default and creditors

never attempt to collect. The model therefore suggests that, even though U.S. bankruptcy filing rates are high, additional households would benefit from filing for bankruptcy but do not actually file because they default and creditors never attempt to collect.

The option value of bankruptcy. Consumer's right to file for bankruptcy can be expressed as a put option with an exercise price equal to the exemption level. Debtors' future wealth is uncertain. If it turns out to exceed the wealth exemption plus the amount owed, then they pay off the debt in full. But if debtors' wealth turns out to be less than this amount, then they exercise their option to "sell" the debt to creditors for a price equal to $\min[X, W_2]$, i.e., they file for bankruptcy.

White (1998) calculated the value of debtors' option to file for bankruptcy. She used household-level data from the PSID, which asks respondents questions concerning their wealth every five years. The calculations were done separately for households at various points in the wealth distribution. The results showed that the value of the option to file for bankruptcy is high for some households in all portions of the wealth distribution. The high value of the bankruptcy option suggests that many households who would not benefit from filing for bankruptcy immediately nonetheless have a positive option value and may find it worthwhile to file for bankruptcy in the future.

The crisis model of bankruptcy. The economic view of bankruptcy and credit markets is controversial and many sociologists and law academics reject it completely. Their view of bankruptcy, as discussed in Sullivan et al (1989) and (2000), is that consumers file for bankruptcy only when unanticipated adverse events such as illness, divorce, or job loss occur that make it impossible for them to repay. In this model, debtors do not plan in advance for the possibility of bankruptcy, but file only when adverse events leave them with no choice.

The crisis model leads to several testable hypotheses. One is that credit availability and interest rates are predicted to be unrelated to bankruptcy exemption levels, because debtors do not take into account the possibility of filing for bankruptcy when deciding whether and how much to borrow. Another testable implication is that whether consumers file for bankruptcy will depend on whether adverse events have occurred and on income, since income affects ability to repay. But bankruptcy decisions will not depend on the financial benefit from filing for bankruptcy. In theory these

differing predictions should allow the economic model of bankruptcy and the crisis model of bankruptcy to be tested against each other empirically.

Overlending. Policymakers in the U.S. often argue that creditors rather than debtors are responsible for high bankruptcy filing rates, because creditors lend too much and debtors therefore find it difficult to repay.[21] One important issue is that U.S. bankruptcy rules make it difficult for lenders to predict whether potential borrowers will repay, since debtors are obliged to use both earnings and wealth to repay outside of bankruptcy, but are only obliged to use their non-exempt wealth to repay in bankruptcy. As a result, lenders must predict both debtors' ability to repay and their probability of filing for bankruptcy. And if debtors decide to behave opportunistically, then they have an incentive to borrow as much as possible before filing.

Another factor is that competition among lenders may create a prisoner's dilemma situation. Suppose there are two credit card lenders, A and B, and each must decide whether to offer credit cards to the other's customers. Suppose S_a equals one if A solicits B's customers and equals zero otherwise and S_b equals one if B solicits A's customers and equals zero otherwise. A's profits are $P_a(S_a, S_b)Q_a(S_a) - C(Q_a(S_a))$ and B's profits are $P_b(S_b, S_a)Q_b(S_b) - C(Q_b(S_b))$. Here $P_a(S_a, S_b)$ and $P_b(S_b, S_a)$ are A's and B's average revenue per cardholder, respectively. Suppose that before any solicitation occurs, A and B have the same average revenue per cardholders, or $P_a(0,0) = P_b(0,0)$. Soliciting by either lender is assumed to lower both lenders' average revenue, so that $P_a(1,0) < P_a(0,0)$, $P_a(1,1) < P_a(0,1)$, $P_b(1,1) < P_b(0,0)$, and $P_b(1,1) < P_b(0,1)$. One explanation for the decline in average revenue is that adverse selection occurs in the response to solicitations (Ausubel, 1999). Thus when A solicits B's customers, those who respond are of lower quality than the average among B's customers, and vice versa. Another explanation is that soliciting increases the total credit available to borrowers who accept the new card and additional credit increases the probability of default (Domowitz and Sartain, 1999). Either explanation implies that soliciting by either lender lowers average revenue for both lenders. $Q_a(S_a)$ and $Q_b(S_b)$ are the total number of cards that A and B issue, which is assumed to depend only on own

[21] Sullivan, Warren and Westbrook (1989) also make this argument.

soliciting. Thus $Q_a(1) > Q_a(0)$ and $Q_b(1) > Q_b(0)$. Finally, $C(Q_a(S_a))$ and $C(Q_b(S_b))$ are A's and B's total cost functions, where average costs are assumed to fall with number of cards issued.

The payoffs of the game are:

		B	
		Solicit	No
A	Solicit	$P_a(1,1)Q_a(1) - C(Q_a(1))$, $P_b(1,1)Q_b(1) - C(Q_b(1))$.	$P_a(1,0)Q_a(1) - C(Q_a(1))$, $P_b(0,1)Q_b(0) - C(Q_b(0))$.
	No	$P_a(0,1)Q_a(0) - C(Q_a(0))$, $P_b(1,0)Q_b(1) - C(Q_b(1))$.	$P_a(0,0)Q_a(S_a) - C(Q_a(0))$, $P_b(0,0)Q_b(0) - C(Q_b(0))$.

Consider whether A and B choose to solicit or not. The dominant strategy equilibrium is for both to solicit if the following two conditions hold for A and analogous conditions hold for B:

$$P_a(1,1)Q_a(1) - P_a(0,1)Q_a(0) > C(Q_a(1)) - C(Q_a(0)) \qquad (11)$$

$$P_a(1,0)Q_a(1) - P_a(0,0)Q_a(0) > C(Q_a(1)) - C(Q_a(0)). \qquad (12)$$

The right side of both conditions is the change in total costs that occurs as a result of A soliciting. The left hand side of (12) gives the increase in A's total revenues from soliciting, assuming that B does not solicit; while the left hand side of (11) gives the increase in A's total revenues from soliciting, assuming that B also solicits. Both lenders are more likely to solicit each others' customers if there are substantial economies of scale in soliciting, if the number of customers that respond to a solicitation increases, and/or if adverse selection is not too severe (i.e., new customers are not much lower in quality than old customers).

Is the mutual soliciting equilibrium inefficient compared the alternative of no soliciting, i.e., does "overlending" occur? Competition among lenders gives consumers an opportunity to borrow more, but opportunistic behavior raises interest rates and makes those who repay worse off. Competition among lenders also may increase or decrease lenders' profits. Whether the "overlending" equilibrium is more or less efficient compared to the no soliciting equilibrium depends on all of these factors.

Bankruptcy as protection for governments.

Finally, another function of the bankruptcy system is to protect the government from the obligation to use the social safety net to bail out consumers who borrow too much and/or turn out to have low wealth in period 2. In the absence of bankruptcy, these debtors would be obliged to repay their debts and, as a result, their consumption might fall so low that they qualify for government assistance. Posner (1995) has argued that bankruptcy benefits the government by transferring some of these costs from the public sector to private lenders.

V. Empirical Research on Bankruptcy and Credit Markets

The Effect of Bankruptcy on Supply and Demand for Credit. In the theoretical section, I argued that bankruptcy exemptions both reduce the supply of credit and increase the demand for credit, although the increase in demand may be reversed at high exemption levels.

The first paper to test these predictions was Gropp, Scholz and White (1997). They used data from the 1983 Survey of Consumer Finance (SCF) to examine how bankruptcy exemptions affect supply and demand for consumer credit. The SCF gives detailed information on debts and assets for a representative sample of U.S. households and it also indicates whether households have been turned down for credit and what interest rates they pay. The GSW study did not distinguish between different types of debt or different types of exemptions, so that their debt variable included both secured and unsecured debt and their bankruptcy exemption variable was the sum of homestead and personal property exemptions. The authors found that borrowers are more likely to be turned down for credit and paid higher interest rates in states with higher bankruptcy exemptions—evidence of a reduction in the supply of credit in high-exemption states. In particular, borrowers were 5.5 percentage points more likely to be turned down for credit if they lived in a state in the highest quartile of the exemption distribution, rather than in a state in the lowest quartile of the exemption distribution. In addition, borrowers in the second quartile of the wealth distribution paid an interest rate that was 2.3 percentage points higher if they lived in a state with combined bankruptcy exemptions of $50,000 rather than $5,000. But borrowers in the third and fourth quartile of the wealth distribution paid interest rates that were not significantly different in high versus low exemption states.

The authors also examined how the amount of debt held by households varied between high versus low exemption states. Although supply and demand for credit cannot be separately

identified, a finding that households hold more debt in high exemption than low exemption states suggests that the increase in demand for credit more than offsets the reduction in the supply of credit, and conversely. The authors found that high-asset households held more debt in high exemption states, while low-asset households held less. Thus when high-asset households increased their credit demand in response to higher exemption levels, lenders accommodated them by lending more. But when low-asset households' increased their credit demand, lenders responded with tighter credit rationing. GSW calculated that, holding everything else constant, a household whose assets placed it in the highest quartile of the asset distribution would hold $36,000 more debt if it resided in a state with combined bankruptcy exemptions of $50,000 rather than $6,000; while a household whose assets placed it in the second to lowest quartile of the asset distribution would hold $18,000 less debt. Thus higher exemption levels were associated with a large redistribution of credit from low-asset to high-asset households.

The results of the study suggest that, while policy-makers often think that high bankruptcy exemptions help the poor, in fact they cause lenders to redistribute credit from low-asset to high-asset borrowers and raise the interest rates they charge low-asset borrowers.

The Effect of Bankruptcy on Secured versus Unsecured Credit. More recent papers on bankruptcy and credit markets distinguished between secured versus unsecured loans and between homestead and personal property exemptions. Berkowitz and Hynes (1999) and Lin and White (2001) both used the Home Mortgage Disclosure Act (HMDA) data to investigate the effect of bankruptcy exemptions on mortgage credit. The HMDA data give information on whether applicants for mortgages and home improvement loans were turned down, as well as the location and some characteristics of the potential borrower. While mortgage loans are always secured, home improvement loans may either be unsecured or take the form of second mortgages. This means that they represent a mixture of secured and unsecured loans.

Berkowitz and Hynes (1999) argued that higher homestead exemptions reduce rather than increase default and therefore lead to an increase in the supply of mortgage credit. Their argument is that, if debtors have defaulted on their mortgages and are in danger of losing their homes, they can file for bankruptcy, obtain discharge of their non-mortgage debts, and use funds that would otherwise go to non-mortgage creditors to pay the mortgage. The higher the exemption levels, the more of debtors' wealth is protected in bankruptcy and therefore the lower the probability that they

will default on their mortgages. Berkowitz and Hynes found support for their hypothesis that higher bankruptcy exemptions lead to an increase in mortgage availability.

Lin and White (2001) extended the bankruptcy decision model discussed above to include two separate decisions by debtors: whether to default on an unsecured loan and whether to default on a mortgage.[22] If debtors default on an unsecured loan, then they are assumed to file for bankruptcy. If debtors default on a mortgage, lenders have the right to foreclose on the house and sell it, regardless of whether the debtor has filed for bankruptcy. The proceeds of selling the house net of transactions costs are used, first, to repay the mortgage, second to repay the second mortgage (if any), and, third, to give the debtor the homestead exemption. Any remaining funds are used to repay unsecured creditors. In the extended model, debtors face uncertainty concerning both their period 2 wealth and their period 2 housing value.

There are several distinct cases, corresponding to different levels of period 2 housing value. In one case, the value of the house is so low that housing equity is more negative than the cost of moving, so that debtors prefer to default on their mortgages regardless of the value of their period 2 wealth, W_2. Debtors also default on their unsecured debt and file for bankruptcy if W_2 turns out to be low, i.e., the bankruptcy decision is the same as in the model just discussed. In other cases, housing value is higher and so debtors would prefer to repay their mortgages and keep their houses. But whether they can do so depends on their realizations of period 2 wealth, W_2. This is the case emphasized by Berkowitz and Hynes, where debtors' ability to repay their mortgages may be enhanced by filing for bankruptcy and obtaining discharge of their unsecured debt. Finally, housing value may be so high that debtors never default on their mortgages and never file for bankruptcy. If W_2 turns out to be too low to repay the unsecured debts, then debtors sell their houses and use the proceeds to repay both loans.

Lin and White show, first, that if the transactions cost of foreclosure is fixed, then neither the homestead nor the personal property exemption level affects the supply of mortgage loans. This is because, when debtors default on their mortgages, lenders foreclose on the house and are repaid before the debtor receives the homestead exemption. So mortgage repayment is independent of

[22] See Brueckner (2000) for a model of mortgage default which is similar to the model discussed above of the bankruptcy decision.

both exemption levels.[23] However a more realistic assumption is that the transactions cost of foreclosure is higher when the debtor files for bankruptcy, because filing for bankruptcy delays the foreclosure process.[24] Then a rise in either exemption reduces the supply of mortgage credit, because debtors' probability of filing for bankruptcy rises and mortgage lenders' return falls when debtors file for bankruptcy. These predictions hold even if borrowers are assumed to file for bankruptcy as a means of increasing their ability to repay their mortgages, as discussed above. Finally, increases in either the homestead or the personal property exemption are predicted to reduce the supply of unsecured credit.

Since the HMDA data cover a series of years in the 1990's, Lin and White tested their model both with and without state fixed effects. The results without state fixed effects rely on cross-state variation in exemption levels. They show that applicants for both mortgage and home improvement loans were significantly more likely to be turned down in states with higher homestead exemptions. When applicants live in states with homestead exemptions that are unlimited rather than in the lowest quartile of the distribution, their probability of being turned down for mortgage loans rises by 2 percentage points and their probability of being turned down for home improvement loans rises by 5 percentage points. When applicants live in states with personal property exemptions of $10,000 rather than $1,000, their probability of being turned down for mortgage loans rises by 1 percentage point and their probability of being turned down for home improvement loans rises by 0.4 percentage points. All of these results are statistically significant. Because the availability of mortgage loans is influenced by exemption levels, the results suggest that the costs of foreclosure are higher when borrowers file for bankruptcy.

When state fixed effects are introduced, the exemption variables capture only the effects of changes in exemption levels that occur during the period covered by the data. In this specification, Lin and White again found that applicants are more likely to be turned down for mortgage and home improvement loans, although the mortgage loan coefficient is only significant at the 10% level. But the relationships between the personal property exemption and the probability of applicants being turned down for either type of loan were insignificant. Because few changes in exemption levels occurred in the years covered by the HMDA data, more years of data will be

[23] This result assumes that mortgage lenders have no claim on other assets of the debtor, even if the proceeds of selling the house are less than the amount of the mortgage.

[24] Borrowers who are behind on their mortgage payments and expect lenders to foreclose often file for bankruptcy under Chapter 13. Doing so allows them to delay the foreclosure proceeding, although they must eventually repay their mortgage arrears in order to avoid foreclosure.

needed to definitely answer the question of whether there is a relationship between credit availability and bankruptcy exemptions.

The Effect of Bankruptcy on Small Business Credit. In the U.S., personal bankruptcy law is the bankruptcy procedure applicable to small businesses as well as to consumers. Owners of unincorporated businesses are legally liable for their businesses' debts. This means that, if the business fails, owners have an incentive to file for personal bankruptcy because both their business and personal debts will be discharged. In contrast, owners of corporations are not legally liable for their corporations' debts, so that personal bankruptcy law in theory is irrelevant to small corporations. But in practice, lenders to small corporations often require the corporation's owner to personally guarantee the loan and/or to give the lender a second mortgage on the owner's house. This muddies the corporate/non-corporate distinction and makes personal bankruptcy law applicable to small corporations as well. About one in five personal bankruptcy filings in the U.S. list some business debt, suggesting the importance of bankruptcy law to small business owners (see Sullivan et al, 1989).

Berkowitz and White (2003) used the National Survey of Small Business Finance to examine how bankruptcy exemptions affect small business credit. They found that if small businesses are located in states with high rather than low homestead exemptions, they are more likely to be turned down for credit and, if they receive loans, interest rates are higher and loan sizes are smaller. For non-corporate firms, the probability of being credit rationed rises by 32% if firms are located in states with unlimited rather than low homestead exemptions; while for corporate firms, the increase is 30%. Both relationships are statistically significant. Conditional on receiving a loan, non-corporate firms paid 2 percentage points more in interest and corporate firms paid 0.83 percentage points more if they were located in states with homestead exemptions at the 75th versus the 25th percentiles of the distribution. Both types of firms receive about $70,000 less credit if they are located in states with homestead exemptions at the 75th rather than the 25th percentiles of the distribution. Thus higher bankruptcy exemptions also reduce the supply of credit to small businesses, both non-corporate and corporate.

VI. The Bankruptcy Filing Decision and Bankruptcy Stigma

Now turn to the empirical studies of the consumer bankruptcy decision. Among the important issues are whether consumers' bankruptcy decisions follow the economic versus the sociological model and whether bankruptcy stigma is an important factor in explaining the decision to file. As discussed above, the economic model of bankruptcy predicts that consumers plan in advance for the possibility of bankruptcy and their probability of filing depends on the financial benefit from doing so. This model implies that the important factors affecting the bankruptcy decision are consumers' assets and debts and the bankruptcy exemption in their state, since these factors combine to determine the financial benefit from filing. The sociological model of bankruptcy assumes that consumers do not plan in advance for bankruptcy and they file only when adverse events reduce their ability to repay. This model implies that the important determinants of the bankruptcy decision are measures of households' ability to repay, including income and whether adverse events such as illness, job loss, or divorce have recently occurred. An important additional issue is the role of social disapproval, or stigma, in the bankruptcy filing decision. Although the bankruptcy procedure in the U.S. is very favorable to individual debtors, they may hesitate to file if social disapproval is strong.[25]

Several papers used aggregate bankruptcy filing data to test the relationship between bankruptcy exemption levels and consumers' probability of filing for bankruptcy. White (1987) used county-level aggregate data from the early 1980's to test this relationship and found a positive and significant relationship between exemption levels and county-level bankruptcy filing rates. Buckley and Brinig (1998) did the same type of study using aggregate data by state during the 1980's, but did not find a significant relationship between filing rate and exemption levels. The Buckley-Brinig results for exemption levels are not surprising, since they included state dummy variables in their analysis. In this specification, the state dummy variables capture the effect of states' initial exemption levels, while the exemption variables themselves capture the effect of changes in exemption levels. Because few states changed their exemption levels during the period, Buckley and Brinig found no relationship between exemption levels and the probability of filing.

[25] Another reason why consumers might avoid filing for bankruptcy is that they may not be able to obtain credit after filing. However a survey by Staten (1993) finds that three-quarters of debtors are able to obtain new credit within a year after filing for bankruptcy, although they tend to pay high interest rates. Some lenders feel that debtors are better credit risks after filing for bankruptcy, since they cannot file again under Chapter 7 for six years.

Efforts to estimate models of the bankruptcy filing decision using household-level data were initially hampered by the lack of survey data on whether individual households have filed for bankruptcy. In an innovative study, Domowitz and Sartain (1997) got around this limitation by combining two data sources: a sample of households that filed for bankruptcy under Chapter 7 in the early 1980's and a representative sample of U.S. households--the 1983 Survey of Consumer Finances (SCF)—that included information on households' income and wealth. They found that households were more likely to file for bankruptcy if they had greater medical and credit card debt and less likely to file if they owned a home. Domowitz and Sartain did not examine the effect of financial benefit or exemptions on the bankruptcy filing decision.

Fay, Hurst and White (2002) were the first to use micro-data to estimate a model of the bankruptcy filing decision--they used panel data from the Panel Study of Income Dynamics (PSID). In 1996, the PSID asked respondents whether they filed for bankruptcy during the period 1984-95 and, if so, in which year. Using the results of the survey and other data collected each year by the PSID, FHW calculated households' financial benefit from filing for bankruptcy each year. For each year they also had information concerning households' income, homeowner status, demographic characteristics, and whether particular adverse events had occurred during the previous year. FHW found that consumers are significantly more likely to file for bankruptcy as their financial benefit from filing increases: if financial benefit increased by $1,000 for all households, then the results imply that the national bankruptcy filing rate will increase by 7 percent each year. Thus the evidence supports the hypothesis that consumers treat filing for bankruptcy as an economic decision. FHW also found that ability to pay affects the bankruptcy decision, since households with higher income were found to be significantly less likely to file. However FHW were not able to cleanly test the economic versus the sociological models of bankruptcy against each other. This is because financial benefit is measured with error, since the PSID does not collect data on wealth every year and, as a result, measured financial benefit is correlated with income. This means that FHW's finding that income is significantly related to the probability of filing for bankruptcy could support either the sociological model (because income itself affects the bankruptcy decision) or the economic model (because financial benefit affects the bankruptcy decision and income is correlated with measured financial benefit). Finally, FHW also examined whether recent adverse events affected the bankruptcy decision by including measures of whether the household head or spouse experienced job loss or a serious illness during the previous year or

whether divorce occurred during the previous year. They found that all three variables were positively related to the probability of filing for bankruptcy, but the job loss and illness variables were insignificant and the divorce variable was only marginally significant. Thus the results provide little support for the sociological model of bankruptcy.

Now turn to the role of bankruptcy stigma in the decision to file for bankruptcy. Gross and Souleles (2002) used a dataset of credit card accounts from 1995 to 1997 to model the decision to default on credit card loans and to file for bankruptcy. They controlled for variables such as the cardholder's riskiness and the length of time since the account was opened. They treat the residual of their model as a measure of the effect of bankruptcy stigma. Gross and Souleles found that, over the two year period of their data, the probability of filing for bankruptcy rose by 1 percentage point and the probability of default rose by 3 percentage points, holding everything else constant. The authors interpret their results as evidence that bankruptcy stigma fell during their time period.

Fay, Hurst and White (2002) used a more direct approach to measuring bankruptcy stigma—they used the aggregate bankruptcy filing rate in the local region during the previous year as an inverse proxy for the level of bankruptcy stigma. Surveys of bankruptcy filers show that they usually learn about bankruptcy from friends and relatives. Filers learn that the bankruptcy process is quick and easy, which reduces their fear of filing. They also learn that friends and relatives view bankruptcy in a favorable rather than a judgmental light, i.e., the level of bankruptcy stigma is lower than they thought. FHW hypothesized that in a region with more bankruptcy filings, people are more likely to learn first-hand about bankruptcy, which reduces their perception of the level of bankruptcy stigma and makes them more likely to file. They tested this by including in their bankruptcy filing model the aggregate bankruptcy filing rate in the household's bankruptcy court district during the previous year. They found that in districts with higher aggregate filing rates (lower bankruptcy stigma), the probability of filing for bankruptcy was significantly higher.

VII. Bankruptcy and The Decision to Become an Entrepreneur

Fan and White (2003) examined whether debtors who live in states with higher bankruptcy exemptions are more likely to own businesses, using panel data from the Survey of Income and Program Participation. They focused on the effect of the homestead exemption, since it is the largest and most variable of the bankruptcy exemptions, and they distinguished between the effects

of the homestead exemption on the behavior of homeowners versus renters, since only the former can take the homestead exemption. Fan and White found that homeowners are 35% more likely to own businesses if they live in states with high or unlimited rather than low homestead exemptions; while the difference for renters was 29%. Both differences are statistically significant. (The fact that exemptions have a large effect on renters' probability of owning businesses may be due to the fact that most renters expect to become homeowners by the time they face the prospect of bankruptcy.) Fan and White also examined the effect of bankruptcy exemptions on decisions to start and end businesses, where starting a business is measured by not owning a business in one year and owning one in the next, while ending a business is the opposite. They found that homeowners are 28% more likely to start businesses if they live in states with unlimited rather than low homestead exemptions, although the relationship is only marginally significant. But they did not find a significant relationship ending a business and the exemption level.

VIII. Bankruptcy and Work Effort

As discussed above, policymakers justify the "fresh start" in bankruptcy (the 100% exemption for post-bankruptcy earnings) on the grounds that debtors work harder after bankruptcy if they are not required to use part of their earnings to repay old debt. But the model discussed above implies that the fresh start in fact has an ambiguous effect on post-bankruptcy labor supply. Outside of bankruptcy, creditors may garnish part of debtors' wages if debtors default. Then if debtors file for bankruptcy, garnishment ends and debtors keep all of their post-bankruptcy earnings. The substitution effect of keeping all their earnings implies that debtors will work more after bankruptcy. But discharge of debt in bankruptcy also increases debtors' wealth and the income effect implies that they will work less after bankruptcy. Overall, bankruptcy could therefore be associated with either an increase or a decrease in work effort.

Han and Li (2004) used the PSID's special bankruptcy survey to test whether consumers work more or less after bankruptcy. They found that filing for bankruptcy is associated with a large--17%--reduction in the number of hours worked by the household head, but the relationship was not statistically significant. Their results suggest that the income effect of debt discharge in bankruptcy is quantitatively more important than the substitution effect of ending debtor's obligation to repay. These results, although tentative, suggest support for reforms that would reduce the exemption for

post-bankruptcy earnings to less than 100%, since these reforms are more likely to be economically efficient if labor supply falls when debtors file for bankruptcy.

IX. Bankruptcy and Consumption Insurance

The model discussed above emphasized the insurance role of bankruptcy and the fact that higher exemption levels are associated with additional insurance. Grant (2003) tested this hypothesis, using data from the U.S. Consumer Expenditure Survey. This dataset gives micro-level information for a rotating panel of households, each of which is interviewed quarterly over a one-year period. To measure the insurance effect of bankruptcy, Grant computed the average variance of household consumption for each state-year covered by the dataset. Then he regressed the change in the variance of consumption from one year to the next on the bankruptcy exemption level, control variables, and state fixed effects. The data have the advantage of covering a 20-year period, so that the number of changes in bankruptcy exemption levels is maximized. In this formulation, the hypothesis is that the coefficient of the exemption variable will have a negative sign, which implies that higher exemptions are associated with lower consumption variance/higher consumption insurance. Grant found that both the exemption variable and a dummy variable for states with unlimited homestead exemptions have the predicted negative signs and the results were statistically significant. Thus the empirical results provide support at a macro level for the hypothesis that higher bankruptcy exemptions are associated with an increase in the level of consumers' certainty concerning their future consumption.[26]

X. Bankruptcy and Portfolio Reallocation

Because unsecured debts are discharged in Chapter 7 bankruptcy but some assets are exempt, debtors who contemplate filing for bankruptcy have an incentive to borrow—even at high interest rates—in order to acquire liquid assets. This is because the liquid assets will be exempt in bankruptcy, while the debts will be discharged. This behavior is referred to as "borrowing to save." The higher the bankruptcy exemption level in the debtor's state, the stronger is debtors' incentive to

[26] Grant (2003) and Lehnert and Maki (2002) have also examined the relationship between bankruptcy and consumption smoothing.

borrow to save. (Similar types of behavior were discussed in section IV above in connection with the proportion of households that would benefit from filing for bankruptcy.)

Lehnert and Maki (2002) examined whether households are more likely to borrow to save if they live in states with higher bankruptcy exemptions. Their definition of borrowing to save is that a household simultaneously holds unsecured debt and liquid assets above a threshold level and also holds liquid assets greater than 3% of gross income. The threshold value was $2000 for renters and $5000 for homeowners. Lehnert and Maki tested their model using household-level panel data from the Consumer Expenditure Survey. The results were that homeowners were 1 to 4 percent more likely to borrow to save if they lived in states with bankruptcy exemptions that were above the lowest quartile of the exemption distribution. Renters were less likely to borrow to save and the relationship was less likely to be statistically significant.

XI. Conclusion

The results of the studies surveyed in this paper suggest that bankruptcy has important and wide-ranging effects on both credit markets and on other aspects of consumer behavior. On the credit market side, generous bankruptcy exemptions increase consumers' demand for credit by providing partial consumption insurance, but cause lenders to reduce the supply of credit by increasing the probability of default. In states with higher bankruptcy exemptions, consumers are turned down for credit more often and pay higher interest rates. If they have high assets, they hold more credit in high-exemption states; while if they have low assets, they hold less credit in high-exemption states. Small businesses are also more likely to be turned down for credit, pay higher interest rates, and hold less credit if they are located in high exemption states. These results apply to both non-corporate or corporate small businesses. Overall, the bankruptcy system causes credit to be redistributed from high exemption to low exemption states and from low asset to high asset borrowers. High bankruptcy exemptions also have other effects on consumer behavior—they cause debtors to behave more opportunistically, reallocate their portfolios toward more unsecured debt and more liquid assets, file for bankruptcy more often, work fewer hours after filing for bankruptcy, and become self-employed more often. But higher bankruptcy exemptions benefit consumers by reducing the variance of consumption, i.e., they provide partial consumption insurance.

References

Athreya, Kartik B., "Welfare Implications of the Bankruptcy Reform Act of 1999," *J. of Monetary Economics*, vol. 49, pp. 1567-1595 (2002).

Ausubel, Lawrence M., "Adverse Selection in the Credit Card Market," Working Paper, Department of Economics, University of Maryland (June 1999).

Bebchuk, L.A., and Michelle J. White (2004), "Bankruptcy Law," in *Handbook of Law and Economics*, edited by A.M. Polinsky and S. Shavell.

Berkowitz, Jeremy, and Richard Hynes (1999), "Bankruptcy Exemptions and the Market for Mortgage Loans," *J. of Law and Econ.*, vol. 42, pp. 908-830.

Berkowitz, Jeremy, and Michelle J. White (2004), "Bankruptcy and Small Firms' Access to Credit." *RAND Journal of Economics*, vol. 35:1, pp. 69-84, Spring.

Brueckner, Jan K. (2000), "Mortgage Default with Asymmetric Information," *J. of Urban Econ.*, vol. 20, pp. 251-274.

Domowitz, Ian, and Michelle Alexopoulos, "Personal Liabilities and Bankruptcy Reform: An International Perspective," *International Finance*, vol. 1, pp. 127-159, 1998.

Domowitz, Ian, and Robert Sartain (1999), "Determinants of the Consumer Bankruptcy Decision," *J. of Finance*, vol. 54, pp. 403-20.

Dye, Ronald A. (1986), "An Economic Analysis of Bankruptcy Statutes," *Economic Inquiry*, vol. 24, pp. 417-428.

Elias, S., A. Renauer, R. Leonard, and K. Michon, *How to File for Bankruptcy, 9th edition.* Berkeley: Nolo Press, 2001

Fan, Wei, and Michelle J. White (2003), "Personal Bankruptcy and the Level of Entrepreneurial Activity," *Journal of Law & Economics*, vol. 46:2, October 2003, pp. 543-568.

Fay, Scott, Erik Hurst, and Michelle J. White (2002), "The Household Bankruptcy Decision," *American Economic Review*, vol. 92:3, June 2002, pp. 706-718.

Fisher, Jonathan D. (2003), "The Effect of Unemployment Benefits, Welfare Benefits and Other Income on Personal Bankruptcy."

Grant, Charles (2003), "Evidence on the Effect of U.S. Bankruptcy Exemptions." This volume.

Gropp, Reint, John K. Scholz, and Michelle J. White (1997), "Personal Bankruptcy and Credit Supply and Demand," *Quarterly J. of Econ.*, pp. 217-51.

Gross, David, and Nicholas Souleles (2002), "An Empirical Analysis of Personal Bankruptcy and Delinquency," *Review of Financial Studies*, vol. 15:1, pp. 319-347.

Han, Song, and Wenli Li, "The Effect of Filing for Personal Bankruptcy on Labor Supply: Evidence from Micro Data," working paper, 2004.

Holtz-Eakin, Douglas, David Joulfaian, and Harvey Rosen, "Sticking It Out: Entrepreneurial Survival and Liquidity Constraints," *J. of Political Economy* 102 (1994): 53-75.

Hynes, Richard M., Anup Malani, and Eric A. Posner (2003), "The Political Economy of Property Exemption Laws," University of Chicago working paper.

Jackson, Thomas H., *The Logic and Limits of Bankruptcy Law*. Cambridge: Harvard University Press, 1986.

Lehnert, Andreas, and Dean M. Maki (2002), "Consumption, Debt and Portfolio Choice: Testing the Effects of Bankruptcy Law." Board of Governors working paper.

Lin, Emily Y., and Michelle J. White, "Bankruptcy and the Market for Mortgage and Home Improvement Loans," *Journal of Urban Economics* 50:1 (2001): 138-162.

Olson, Martha L., "Avoiding Default: The Role of Credit in the Consumption Collapse of 1930," *Quarterly J. of Econ.*, pp. 319-335 (1999).

Posner, Eric A. (1995), "Contract Law in the Welfare State: A Defense of the Unconscionability Doctrine, Usury Laws, and Related Limitations on the Freedom to Contract," *J. of Legal Studies*, vol. 24:2, pp. 283-319.

Rea, Samuel A. (1984), "Arm-Breaking, Consumer Credit and Personal Bankruptcy," *Economic Inquiry*, vol. 22, pp. 188-208.

Staten, Michael (1993), "The Impact of Post-Bankruptcy Credit on the Number of Personal Bankruptcies," Credit Research Center, working paper no. 58, Purdue University.

Sullivan, Theresa, J. L. Westbrook, and Elizabeth Warren (1989), *As We Forgive Our Debtors: Bankruptcy and Consumer Credit in America*. New York: Oxford University Press.

Sullivan, Theresa, J. L. Westbrook, and Elizabeth Warren (2000), *The Fragile Middle Class: Americans in Debt*. New Haven: Yale University Press.

Visa U.S.A., Inc. (1997), *Consumer Bankruptcy: Annual Bankruptcy Debtor Survey*.

Wang, Hung-Jen, and Michelle J. White (2000), "An Optimal Personal Bankruptcy System and Proposed Reforms," with Hung-Jen Wang. *Journal of Legal Studies*, vol. XXXIX(1), pp. 255-286.

White, Michelle J. (1998a), "Why it Pays to File for Bankruptcy: A Critical Look at Incentives under U.S. Bankruptcy Laws and A Proposal for Change," *University of Chicago Law Review*, vol. 65, pp. 685-732.

White, Michelle J. (1998b), "Why Don't More Households File for Bankruptcy?" *Journal of Law, Economics, and Organization*, vol. 14:2, pp. 205-231, Oct.

White, Michelle J. (1994), "Corporate Bankruptcy as a Filtering Device: Chapter 11 Reorganizations and Out-of-Court Debt Restructurings," *J. of Law, Economics and Organization*, vol. 10, Oct. 1994, pp. 268-295.

White, Michelle J. (1996), "The Costs of Corporate Bankruptcy: A U.S.-European Comparison," in *Corporate Bankruptcy: Economic and Legal Perspectives*. J. Bhandari and L. Weiss, eds. Cambridge University Press.

Figure 1: The Insurance Effect of Bankruptcy

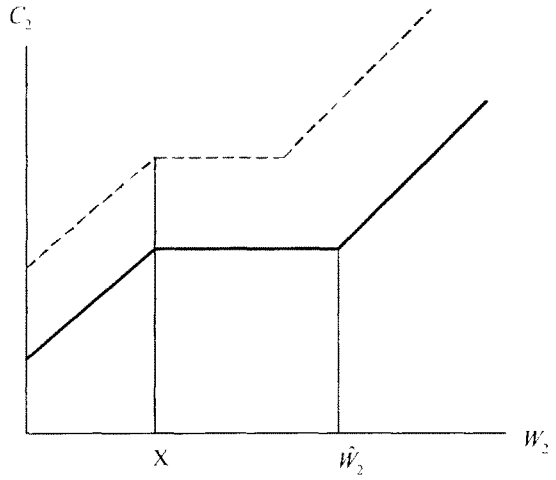

Table 1:
Non-business and Business Bankruptcies
1980-present

Year	Number of non-business bankruptcy filings	Number of business bankruptcy filings
1980	241,431	36,449
1985	297,885	66,651
1990	660,796	64,688
1995	806,816	51,878
2000	1,240,012	35,472
2002	1,539,111	38,540
2003	1,625,208	35,037

Source: *Statistical Abstract of the United States*, *2002*, table 724, and *1988*, table 837, and data from Administrative Office of the U.S. Courts.

Table 2:
Personal Bankruptcy Exemptions in the U.S., 2001

Homestead Exemptions	State
0 – $7,500	Alabama, Delaware, District of Columbia, Georgia, Kentucky, Illinois, Indiana, Maine, Maryland, Michigan, New Jersey, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia
$8,000 – $30,000	Colorado, Hawaii, Louisiana, Missouri, Nebraska, New Hampshire, New Mexico, New York, Nebraska, North Carolina, Oregon, Utah, West Virginia, Wyoming, Federal exemption
$40,000 – $100,000	Arizona, California, Connecticut, Idaho, Massachusetts, Mississippi, Montana, North Dakota, Rhode Island, Vermont, Washington, Wisconsin
>$100,000 - $250,000	Alaska, Minnesota, Nevada
Unlimited	Arkansas, Florida, Iowa, Kansas, Oklahoma, South Dakota, Texas

Personal Property Exemptions	State
$2,000 – $4,500	Alabama, Florida, Indiana
$5,000 – $8,700	Delaware, Illinois, Louisiana, Maryland, Massachusetts, Missouri, Nebraska, North Carolina, North Dakota, Ohio, South Dakota, Tennessee, Utah, Wyoming
>=$10,000	Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Federal exemption

States that allow bankrupts to use either the state or the Federal exemptions	State
	Arkansas, Connecticut, District of Columbia, Hawaii, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico,

	Pennsylvania, Rhode Island, Texas, Vermont, Washington, Wisconsin

Notes: The exemptions given are for single filers. Some states allow married couples to double the homestead exemption and some the elderly or disabled to take higher exemptions. States usually have a number of different personal property exemptions for items such as clothing, equity in cars, furniture, jewelry, tools of the trade, burial plots, or damage awards. These may be specified either as maximum dollar values or as blanket exemptions for the particular type of property. Some states also have a dollar-denominated "wildcard" exemption that applies to any type of property. The personal property exemptions listed in table 1 are the sum of all personal property exemptions for which a maximum dollar value is given. In addition to these exemptions, some states have exemptions for retirement accounts and life insurance policies. Source: Author's calculations from data in Elias et al (2001).