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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

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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

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[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]

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

Tuesday, July 28, 2009

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

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

Methodology of the Consumer Bankruptcy Project[1]

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

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

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[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

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

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

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

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

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

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

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.

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[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).