



**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**

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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

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 debt³. 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 Mathur⁴; Northwestern University economics professors David Dranove and Michael Millenson⁵; economics professors Scott Fay, Erik Hurst, and Michelle White from University of Florida, University of Chicago, and University of California, San Diego respectively⁶; and economist David Gross from Compass Lexecon and economics professor Nicholas Souleles from the University of Pennsylvania⁷.

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

³ The Federal Reserve Board, "Survey of Consumer Finances," 2007. Available at: <http://www.federalreserve.gov/pubs/oss/oss2/scfindex.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 Affairs*, 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 Act⁹, the Senate Finance Committee’s America’s Healthy Future Act of 2009¹⁰, and the House Education

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. Washington: 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 2009¹¹ – 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.

¹¹ U.S. House "America's Affordable Health Choices Act of 2009". 111th Congress, 1st session. H.R. 3200. Washington: 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

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

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 hour¹⁷ was followed by record teen unemployment rates, the latest almost 26 percent in September¹⁸. 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

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.

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 Medicaid²³ while in Michigan the number of doctors who do not see Medicaid patients has risen from 12 percent in 1999 to 36 percent in 2005²⁴. Physicians do not want to take Medicaid patients because of low reimbursement and substantial paperwork. A

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

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.

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.

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