

MEDICAL DEBT: IS OUR HEALTHCARE SYSTEM BANKRUPTING AMERICANS?

HEARING BEFORE THE SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW OF THE COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES ONE HUNDRED ELEVENTH CONGRESS FIRST SESSION

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MEDICAL DEBT: IS OUR HEALTHCARE SYSTEM BANKRUPTING AMERICANS?

TUESDAY, JULY 28, 2009

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

The Subcommittee met, pursuant to notice, at 11:11 a.m., in room 2141, Rayburn House Office Building, the Honorable Steve Cohen (Chairman of the Subcommittee) presiding.

Present: Representatives Cohen, Conyers, Delahunt, Watt, Maffei, Lofgren, Scott, Franks, Jordan, Coble, Issa, and King.

Staff present: James Park, Majority Counsel; Adam Russell, Majority Professional Staff; and Daniel Flores, Minority Counsel.

Mr. COHEN. This hearing of the Committee on the Judiciary, Subcommittee on Commercial and Administrative Law, will now come to order.

Without objection, the Chair will be authorized to declare a recess of the hearing. And I will now recognize myself for a short statement.

Two years ago, this Subcommittee held a hearing on a Harvard study which examined 2001 bankruptcy filing data in five select judicial districts around the country. That study concluded that illness or high medical bills contributed to almost half of all the bankruptcy filings that were studied.

Today we revisit the issue of medical debt as a contributor to bankruptcy. The authors of the study have now released an updated version, published online last month in the *American Journal of Medicine*, based on 2007 data of bankruptcy filings nationwide.

Disturbingly, this study concludes that 62 percent of bankruptcy debtors can trace at least part of the cause of their bankruptcies to medical debt.

The 2007 data also indicate that there was a—nearly a 50 percent increase in medical bankruptcies as a proportion of bankruptcy filings between 2001 and 2007.

The updated study further suggests that medical debt is driving middle-class families into bankruptcy. Of those classified in the study as medically bankrupt, more than 60 percent attended college. More than 66 percent at one point owned a home. And 78 percent had health insurance at the time they became sick or injured.

Accordingly, it is obvious that medical bankruptcies are not the fault of people keeping track of their assets and liabilities. They are the victims of life's lottery.

Ultimately, the problem lies with the runaway cost of health care in America—simply too expensive for millions of Americans to buy any health insurance at all.

And even for those who have insurance, excessive premiums and deductibles, low coverage caps and uninsured medical conditions are just some of the reasons why Americans with health insurance are left one serious illness away from financial disaster.

And when that financial disaster may hit, it hits hard. Studies show that many are skipping recommended treatments, not filling critical prescriptions, pharmacists—postponing doctor appointments, and cutting back on other essentials like food in order to stay financially afloat. Often, the debt becomes so burdensome that Americans are faced with no other choice but bankruptcy.

Medical bankruptcies have a collateral effect on creditors, because when you have a medical bankruptcy, all creditors lose, which means small business loses, which is an important reason why small business and creditors in general benefit from a health care system that doesn't drive American citizens into bankruptcy, where we lose the opportunity to collect on lawful debts.

It is my sincere hope that today's hearing will help us better understand the extremely serious consequences of medical debt and serve to galvanize us to work toward finding solutions.

I welcome ideas for amending the bankruptcy code to help provide needed relief for the medically bankrupt. I am certainly open to revisiting some of the more onerous provisions of the 2005 Bankruptcy Abuse Prevention and Consumer Protection Act, and particularly the means test and the credit counseling requirement.

Credit counseling certainly can't help a person who has gone into bankruptcy because they have a major medical problem. That is something that—maybe a checkup with a doctor could do more good, and the credit counseling becomes a waste of time.

Perhaps this could achieve a better balance between creditors' rights and the need for relief for honest medical debtors.

In addition to exploring bankruptcy law changes, I believe the long-term solution to runaway health care costs is to enact meaningful health care reform. I would be remiss if I did not recognize the leadership of the distinguished Chairman of this Committee, the Honorable John Conyers.

He has drawn attention to this important issue over the years, and I applaud him for his efforts to bring about legislative change in the medical field and for universal coverage.

The updated Harvard study should be a useful reminder as to why Congress must consider refining the bankruptcy code and reforming our health care system to provide much-needed relief to those with overwhelming medical debt. Not to do so would be a crime.

I thank the witnesses for appearing today, and I look forward to their testimony.

I now recognize my colleague, Mr. Franks, the distinguished Ranking Member of the Subcommittee, for his opening remarks.

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

And thank all of you for being here. It is another wonderful day in the capital here. We are glad that we can go forward here. Thank you.

Mr. COHEN. Mr. Rogers.

Mr. FRANKS. Absolutely. It is a wonderful day in the neighborhood. It is a great day.

The question this hearing title presents, "Is our Healthcare System Bankrupting Americans," quote—it is relatively easy to answer, in my opinion, and that answer is no.

The empirical evidence, aside from the one Harvard study, the university study the Chairman has mentioned, demonstrates there has been no increase in the number of bankruptcies caused by medical debt.

Medical bills and medical problems, Mr. Chairman, to be sure, are, indeed, a source of deep concern for many American families, and unfortunately, in some cases, these problems lead families into bankruptcy.

But this is why the bankruptcy code allows low-income debtors to discharge their medical debts completely and higher-income debtors to pay back only what they can afford.

In short, the bankruptcy code already tries to strike an appropriate balance between debtors and creditors, including health care providers. And I believe it is unwise to change that mechanism.

However, the government-run health care system that really is at the top of the majority's agenda I think is the main reason we are here today, not really to talk about the reforms to the bankruptcy code.

I suspect that we are here to discuss why a new Harvard study on medical debt and bankruptcy should lead us to conclude that this country needs a government-run health care system.

There are at least two problems with that argument—since medical debt plays a significant role in bankruptcy filings, we need, therefore, government-run health care—in other words, we we make that leap.

But first, the Harvard study that is the foundation for this argument, is fundamentally unsupportable. The study's findings rest primarily on the way researchers define and count what constitutes a medical bankruptcy, instead of on an actual increase in medical-debt-related bankruptcies.

Indeed, even assuming the researchers' methodology is correct, in absolute numbers, medical debt bankruptcies actually decreased between the years of 2001 and 2007.

Yet by using percentages instead of actual numbers, the researchers claim that medical debt bankruptcies increased during that same time period.

Moreover, Mr. Chairman, no other study of medical debt and bankruptcy has reported a correlation anywhere near as the 62 percent correlation the Harvard study finds.

Second and perhaps most important, in terms of decreasing the number of bankruptcies in America, there is little reason to believe that a government-run health care system will have much of an impact. One only needs to look at Canada to see why this is true.

According to a study by the Fraser Institute, the consumer bankruptcy in Canada was higher than the bankruptcy rate in the

United States in 2006 and 2007, despite the fact that Canada has a universal, single-payer, government-run health care system.

Somebody said a long time ago that a smart man learns from his experience and a wise man learns from other people's experience. And I hope that we will look to other people's experience with the government-run health care.

If we had government-run health care like Canada has, Mr. Chairman, we are still looking at Canada having a higher bankruptcy than we do in the last couple of years.

It is projected that the health care legislation the majority is trying to move through Congress will eliminate up to 5 million jobs. Certainly, the loss of 5 million jobs will have a far greater impact on the number of Americans filing for bankruptcy than medical debt, even using the Harvard study's inflated numbers.

Every American, regardless of health or financial status, should have access to affordable health care and the coverage, in my opinion, of their choice. But we should not be making decisions on how to improve America's health care system based in any part on a flawed medical debt bankruptcy study. Nor should we use that study as a bankruptcy for modifying the bankruptcy code.

Mr. Chairman, I heard that if you have a cold in Canada, you call a doctor. If you have something serious, you call a travel agent. So I just thought I would throw that in while we are walking by this way.

I look forward to the witnesses' testimony and yield back the balance of my time.

Mr. COHEN. I thank the gentleman for his statement. And since he did reference the Chairman there, I would want him to know that we are not fashioning our health care program after Canada, and we have a much warmer and fuzzier system we have planned.

And we do intend—Americans, we are sure, will continue to call their travel agent to go to Canada, which is a nice place to travel to.

I now recognize our distinguished Judiciary Committee Chairman, a leader on all things that are good, Mr. John Conyers, for his opening statement.

Mr. CONYERS. Thank you, Chairman— [Applause.]

Mr. COHEN. Here, here. Here, here.

Normally applause is not allowed, but for the Chairman it is encouraged. [Laughter.]

Mr. CONYERS. Well, this is a good way to start off a hearing, because I wanted my dear friend, the Ranking Member, Mr. Franks of Arizona, to get all of these supposed problems out of his system and get them on the table so we can examine them.

This is almost like a medical diagnosis that we do in the legislature. We find out what is wrong, how you are feeling, and what you believe, and we lay it out on the table and then we start talking through it.

And that is what brings us here today. I have rarely been in a room in a hearing to have Elizabeth Edwards, Stephanie Woolhandler, Professor Pottow, Dr. Patch Adams in the office, our movie starlet Donna Smith, and there are probably others here.

And then to have all of my colleagues—the Chairman, Bill Delahunt, the gentleman from Virginia, Bobby Scott, Maffei, and of

course, Mel Watt himself—and what we want to try to do is examine these premises and we can't do it with a better group than the ones that we have here.

I am worried about this health bill, by the way. Like my friend from Arizona, I, too, am worried about H.R. 3200, maybe for different reasons, but look. We are not insuring everybody, and anybody using the term “universal” applied to this patchwork, well-intentioned patchwork, of legislative ideas is erroneous.

And the other thing—there is a—what do you call it, the donut hole for the medically uninsured? What did you call it? There is a donut hole for the medically uninsured inside this bill. And we will be talking about it.

Now, in addition, I do celebrate the fact that our colleague from Ohio, Dennis Kucinich, was able to get through an amendment that allows states to use single-payer, to experiment with it, which they cannot do now without this amendment. And I am fighting to keep that in the bill.

And so I look forward to the proceedings. I want to tell my friend on the—from Ohio, Jim Jordan, that I sent my congratulations to him this morning and that—

Mr. JORDAN. I got that.

Mr. CONYERS. I am glad you did, because, you see, we have to work together. The essence of democracy isn't how much you can dis the other person or personalize attacks and misrepresent facts.

The essence of democracy is that we can have honest views about conservatism, progressivism, and what a democracy really ought to stand for and still remain friends.

And so I yield back the balance of my time.

Mr. COHEN. Thank you, Mr. Chairman.

We are going to ask that the other Members' opening statements be concluded in—be included in the record, except for those people who are Tarheels, and we have a Tarheel exception, and I first will recognize our Republican Tarheel, Mr. Coble.

Mr. COBLE. Well, thank you. Thank you, Mr. Chairman. I will be—

Mr. COHEN. I don't know why I have trouble with that. Mr. Coble.

Mr. COBLE. I will be very brief. I won't take anywhere near the five. But, Mr. Chairman, thank you for calling this hearing.

And I want to welcome all of our witnesses, and particularly Mr. Watt's and my fellow North Carolinian, Mrs. Edwards.

Good to have you, Mrs. Edwards.

Good to have all of you with us.

Thank you, Mr. Chairman. Yield back.

Mr. COHEN. Thank you, sir. Thank you, sir.

And now I recognize the distinguished gentleman from North Carolina—the other distinguished gentleman from North Carolina, Mr. Watt.

Mr. WATT. Thank the gentleman for the recognition, and I want to join with my colleague Mr. Coble and my other colleagues in welcoming Elizabeth Edwards.

I don't really know of a more public and ardent and thoughtful advocate in the health care arena who is not herself a—or himself

a doctor or with medical training. She has just been a wonderful spokesperson for health care reform.

And I am looking forward to her testimony as well as the other witnesses. I don't mean to discount anybody's testimony about this important subject.

We actually have a number of different standards in the bankruptcy laws for a number of different things. We have got a whole section on agricultural bankruptcies, farms.

We are putting in place resolution authority for systemically threatening financial institutions that wouldn't be part of the regular bankruptcy code.

There are all kinds of exceptions, and yet there is no real carve-out or exception for medical conditions which apparently cause a lot more bankruptcies than we could ever imagine based on the research.

So I look forward to it. I think it is an important hearing. And I particularly welcome my good friend and longtime friend Elizabeth Edwards and look forward to her testimony.

And I won't abuse the system any longer. Although he did say Tarheel, so I would remind him that we won the national championship this year, as opposed to Tennessee. That is why he is so deferential to us, I think, in addition to having an outstanding witness here to testify on that—on the subject of the day.

I yield back. I am sure he will get the last word.

Mr. COHEN. Thank you, Mr. Watt. No, but North Carolina's trip to the championship did go through Memphis, and I was there, and I cheered for them.

I am now pleased to introduce the witnesses and to hear the testimony for today's hearing.

First, I want to thank each of you participating in today's hearing. Without objection, your written statements will be included in the record. I would ask you to limit your oral remarks to 5 minutes.

There is a lighting system for time. Green light means you have started and you—within the first 4 minutes, and then at the 4-minute mark it turns yellow. And the yellow brick road leads to the red sign, which means your time is up.

Most people don't pay attention to that, but we would hope that we would start to pay attention to that a little bit and you would start to wind up your remarks, at a minimum, when it gets to be red.

After you have completed your testimony, Subcommittee Members will have 5 minutes to ask you questions.

Our first witness is Ms. Elizabeth Edwards. She is a senior fellow at the Center for American Progress Action Fund, where she works on health care issues. A passionate advocate for children and an accomplished attorney, she has been a tireless worker on behalf of important social causes for many years.

She worked for the North Carolina Attorney General's Office in the early 1980's and worked at the Department of Natural Resources and Community Development and CETA. From 1984 to 1996, she was in private practice, and she worked in bankruptcy courts—particularly relevant for us here.

She taught at the UNC Law School for 2 years, and she was a member of the first group of public fellows at the College of Arts and Sciences at the University of North Carolina, the NCAA basketball champion.

Thank you, Mrs. Edwards. Will you please begin your testimony?

**TESTIMONY OF ELIZABETH EDWARDS, SENIOR FELLOW,
CENTER FOR AMERICAN PROGRESS ACTION FUND**

Mrs. EDWARDS. There. All right.

Chairman Cohen and Members of the Subcommittee, thank you for inviting me here today to discuss the problems individuals face when they cannot afford health insurance or health care.

As a person who spent the majority of her legal career in bankruptcy court representing bankruptcy trustees, and as someone who has spent her post-legal career dealing with health care policy, I have to disagree, unfortunately, with Congressman Franks. The answer to the question posed by this hearing is yes, our health care system is bankrupting Americans.

We are in the middle of a great national debate on health care. For the first time in 15 years, we are truly trying to fix a problem of 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 adequate health care coverage.

I know the Committee is particularly interested in the financial hardships that many Americans experience due to health care costs.

People with poor health insurance coverage or no health insurance coverage and a significant health problem are particularly likely to accrue considerable medical debt and are thus particularly vulnerable to bankruptcy.

Medical debt is a symptom of larger problems in our health care system. And although we can take some ameliorative steps, the real solution to medical debt and medical bankruptcy is real health care reform that results in affordable, reliable insurance coverage for all Americans.

The problem can be pinpointed further. It is a problem of insurance coverage, which is unaffordable for 47 million Americans, and the—sadly, people who even have health insurance increasingly face problems paying for health care.

Seventy-five percent of those filing for bankruptcy had—because of medical debt have health insurance—obviously, inadequate health insurance. Some of these are part of the 25 million adults in America who the Commonwealth Fund identified as under-insured.

Even moderate levels of out-of-pocket spending relative to family income created medical bill problems, because many families have little wiggle room, particularly in this economy, within their family budget for large or unexpected out-of-pocket health care expenses.

Still another study found that one in five, 20 percent of us, reported problems paying medical bills, and that was in 2007. I don't expect it has gotten any better.

Health care affordability is particularly elusive for individuals with chronic illnesses and other conditions that require ongoing, often costly medical care.

In particular, individuals who are older, have activity limitations, have chronic conditions such as diabetes, heart disease, arthritis, or have experienced a stroke are more likely to spend a higher proportion of their income on health expenses. So this problem of medical debt hits the most vulnerable people at the worst possible time.

Of sicker uninsured adults, three-fifths reported being contacted by a collection agency.

In a 2007 survey, respondents reported making difficult choices between using up a lifetime of savings; running up credit card debt, often to cover those medical costs; skipping the purchase of other necessities or adding a mortgage against their home in order to pay medical billions.

So broader financial problems which are often masked in some statements are another hazard of uninsurance or under-insurance.

Many medical debtors turn to borrowing to cover accrued medical expenses in order to continue treatment, which is why the study that was done by Harvard is so illuminating, and continuing treatment may be their highest priority—in fact, probably should be their highest priority.

For example, a recent debtor in North Carolina—this was just last week—had incurred medical expenses for a child who needed cardiac surgery. A large part of the cost—so he was insured. A large part of the costs were not covered by the insurance policy. He borrowed money against his credit cards in order to pay for that first surgery, but that wasn't his worst problem.

Like many medical debtors, the surgery was the beginning, not the end, of the treatment. A second surgery was required. The medical providers would not do that surgery until the first bill was paid, so that required the charges against the credit card.

After the second surgery, there were \$30,000 of unreimbursed costs that had been borne by this particular debtor to pay for his child's cardiac surgery, and the father was forced into bankruptcy.

The need for continuing care from the health care provider slash creditor puts these particular kinds of costs in a unique category in our bankruptcies. In some cases, bankruptcies may be driven not by under-insurance or by bad—by insurance but, in fact, by bad insurance policies.

Those who suffer from a wrongful rescission or denial of legitimate claims include not only the debtor, who is obviously disadvantaged, but also, as the Chairman mentioned, it disadvantages other creditors, particularly unsecured small business creditors whose debts are devalued by the inclusion of unreimbursed costs in the bankruptcy filing.

The problems I have outlined in my testimony—families forced into bankruptcy, people with chronic conditions going into—going without necessary care, low-income families experiencing the squeeze of unexpected medical bills—are merely a symptom of our larger problem in our health care system.

Today we leave too many Americans without health insurance and many more without adequate coverage. Congress can fix these problems.

But in order to do so, we need to address the health care issue in addition to addressing some issues we can in bankruptcy—considering those rescinded contracts, for example, or perhaps permit-

ting medical debtors to file again before the statutory limit on repeat filings, in order that they deal with those medical costs and continue—can continue to get the care that they need.

Thank you for your attention. I look forward to working with you and the Nation as the Nation moves forward with these needed changes in our health care reforms.

[The prepared statement of Mrs. Edwards follows:]

PREPARED STATEMENT OF ELIZABETH EDWARDS

Center for American Progress Action Fund



Statement of

Elizabeth Edwards

Senior Fellow

Center for American Progress Action Fund

Before the

Subcommittee on Commercial and Administrative Law

Committee on the Judiciary

United States House of Representatives

Hearing on: "Medical Debt: Is Our Healthcare System

Bankrupting Americans?"

July 28, 2009

Chairman Cohen and Members of the Subcommittee, thank you for inviting me here today to discuss the problems individuals face when they cannot afford health insurance or health care. 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 particularly interested in the financial hardships that many Americans experience due to health care costs. As Dr. Woolhandler will note, medical expenses are a major factor in a majority of bankruptcy filings. People with poor or no health insurance coverage and a significant health problem are particularly likely to accrue considerable medical debt – 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

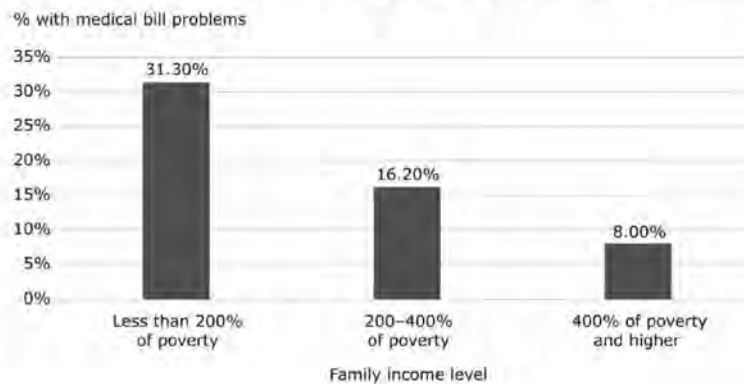
below 200 percent of the federal poverty level—or approximately \$44,000 for a family of four. Most people without health insurance are workers or live in families with a worker, but do not have health coverage through an employer.¹ With the annual average cost of employer-sponsored health insurance nearing \$13,000 in 2008, health insurance is clearly unaffordable for families who must purchase it on their own.²

Sadly, even people who actually have health insurance increasingly face problems paying for health care. Research documents that 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 2003.³

Another study, which explored families' actual problems paying medical bills, found that one in 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.⁴ 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.)

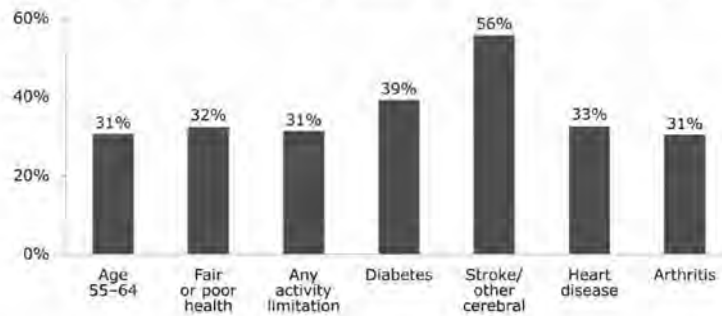
Burden of medical bills for families spending 2.5% or less of family income



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 next page.) 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 Benthin, 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.⁵

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 cost⁶ 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.⁷ 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%).⁸

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.⁹

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.¹⁰

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 medical expenses for a child who needed cardiac surgery that were not covered by insurance. 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.

The Role of Reform

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, 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

I along with every other American are counting on the Congress and the President to enact reform that will provide answers to these question—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 14,000 people be losing health coverage every day in this recession? 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.

¹ Kaiser Family Foundation, *The Uninsured: A Primer*, October 2008, available at: <http://www.kff.org/uninsured/upload/7451-04.pdf>.

² Kaiser Family Foundation/Health Research and Education Trust, "Employer Health Benefits 2008 Annual Survey," available at: <http://ehbs.kff.org/?page=charts&id=1&sn=6&p=1>.

³ 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.

⁴ 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.

⁵ Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care," *Report Brief*, February 2009, available at:

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⁶ C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1.

⁷ C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1.

⁸ 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>.

⁹ 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>.

¹⁰ 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

Mr. COHEN. Thank you very much, Mrs. Edwards.

Our second witness is Stephanie Woolhandler. On the Harvard faculty since 1987, Dr. Woolhandler has conducted research and published her results in dozens of articles, chapters and books.

She still provides patient care as an attending physician at the Cambridge Hospital and serves as co-director of the school's General Internal Medicine Fellowship Program.

Numerous honors and awards have recognized her contributions to health care. She advocates guaranteed access to health care for

all members of society, including the 42 million Americans currently without medical insurance.

In 1986, she helped found Physicians for the National Health Program, a not-for-profit organization for physicians, medical students and other health care professionals who advocate for a national health insurance program.

Thank you, Dr. Woolhandler. Appreciate your work. And you could begin your testimony.

**TESTIMONY OF STEFFIE WOOLHANDLER, M.D., M.P.H.,
PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL**

Dr. WOOLHANDLER. Mr. Chairman, Members of the Committee, as Mr. Cohen said, I am Steffie Woolhandler. I am a primary care doctor in Cambridge, Massachusetts and a professor at Harvard.

And I am the senior author of the two studies on medical causes of bankruptcy that we have been discussing. One appeared in Health Affairs in 2005 and the latest is in the August 2009 issue of American Journal of Medicine.

They are actually quite large studies. The first one had about 1,700 people in bankruptcy courts who we surveyed. The most recent one has 2,300 debtors in bankruptcy court.

In that most recent study, medical bills and illness contributed to, as many people have said, 62 percent of our bankruptcies. And the proportion of bankruptcies attributed to medical problems rose by about 50 percent.

The striking conclusion from the study is really that private insurance is a defective product. It is a defective product. It leaves millions of middle-class Americans vulnerable to financial ruin.

And unfortunately, the health reforms now under consideration in the House would do little to address this grave problem—that is, reforms other than single-payer. They will not address the problem.

We found that most of the medical bankrupt were middle class, at least when their financial crisis hit. Two-thirds were homeowners. Three-fifths had gone to college. High medical bills were part of a web of problems. Often they lost their job because they were ill and with it lost their insurance just as the bills started to roll in.

As was mentioned before, the overwhelming majority of those in bankruptcy had health insurance. Seventy-eight percent were insured at the start of the bankrupting illness.

And the majority of them actually had private coverage, and the majority of those actually held onto their coverage throughout the bankrupting illness but were bankrupted anyway by co-payments, deductibles and gaps in coverage, which will continue to be legal in the House bill.

These families have done everything right. They have worked hard, paid their premiums and thought they were covered. Yet on average, they ran up bills—people with private insurance ran up bills of nearly \$18,000, including folks who held onto the insurance throughout the illness.

So this is not an issue of rescissions. It is an issue that private health insurance is fundamentally defective.

I think our study raises a warning flag that leaving most Americans to rely on private insurance is going to leave them unprotected.

And unfortunately, a public plan option that mimics the rules and coverage of private plans won't help. It will still have those co-payments, deductibles and other gaps.

Now, in Massachusetts we have 3 years of experience with the kind of plan the House is now debating, and it is actually pretty sad experience. Reform has not made health care affordable for our middle class and has decimated—decimated—the safety net on which poor people and mentally ill people, continue to rely.

In 2007, only 5 percent of Massachusetts residents were uninsured. That was the lowest rate in the Nation. And yet medical problems in 2007 were still responsible—still underlaid three out of every five bankruptcies—essentially the same proportion as nationally.

In our state, failure to buy insurance is illegal, punishable by a \$1,000 fine, which is the same fine you get for beating your wife or making a terrorist threat.

For a middle-income 56-year-old, the cheapest coverage available through the state's Connector—and you can go on the state's Web site to see—the state's insurance exchange offers you a policy—\$4,900 for a policy with a \$2,000 deductible before it pays for care and 20 percent co-payment after that.

That is going to be—what is being proposed in the House bill is identical to Massachusetts. A diabetic with such coverage would quickly run up bills of about \$10,000 a year and in 2 years he would accumulate bills large enough to bankrupt him, if he was like the people in our study.

This kind of insurance, sold with a stamp of approval of our state, in a reform similar to the one you are considering—the stamp of approval of the Connector is a cruel joke, and Congress should not repeat that.

For everyone financially ruined by illness, many more are physically suffering because they can't get the care they need.

Access to an insurance policy is not the same thing as access to care. Eighteen percent of people in our state skipped health care last year because they couldn't afford it. We are supposed to be the model. Eighteen percent skipped care because they couldn't afford it.

Moreover, if those people show up at safety-net hospitals and clinics, they are going to find them shuttered or cutting back on services. Our governor and legislature, desperate to keep the reform afloat as costs have escalated more rapidly than predicted, has drained funds from that safety net.

Reform needs to replace the defective private insurance that most families have with insurance that is always there, that covers all medically necessary care, without gaps like co-payments and deductibles.

That is the kind of coverage people in other wealthy nations get through single-payer national health insurance. Only single-payer national health insurance can make universal comprehensive care affordable by saving literally hundreds of billions of dollars every year that we now waste on insurance overhead and bureaucracy.

In nations like Canada that have single-payer health plans, medical bankruptcy is rare—about 12 percent of all bankruptcies.

Unfortunately, overwhelming evidence indicates that the reform that the House now seems poised to pass will fail to protect Americans unless it gets rid of the defective product that is private health care—private health insurance, excuse me. We will have private health care, but just no private health insurance, with single-payer. Thank you.

[The prepared statement of Dr. Woolhandler follows:]

PREPARED STATEMENT OF STEFFIE WOOLHANDLER

**Written Testimony of Steffie Woolhandler M.D., MPH
House Judiciary Committee, Subcommittee on Administrative and Commercial Law
July 28, 2009**

I am senior author on two studies on medical bankruptcy, the most recent of which appears in the August 2009 issue of the American Journal of Medicine. For this study we surveyed 2,314 American families filing for bankruptcy and found that medical problems contributed to 62.1 percent of all bankruptcies in 2007. In addition to obtaining written surveys from all 2,314 families, we also carried out extensive telephone interviews with 1,032 of these debtors.

Between 2001 and 2007, the proportion of all bankruptcies attributable to medical problems rose by nearly half. In order to compare the medical bankruptcy rates in 2007 and in our 2001 study we had to use the same definitions in both years. Our 2001 study had used a less stringent (“legacy”) definition of medical bankruptcy that included families with more than \$1000 in unpaid medical bills. Using this “legacy” definition, the medical bankruptcy rate rose from 46.2% in 2001 to 69.1% in 2007 - a 49.6% increase. This is clear evidence that health care is becoming less affordable to American families, including American families with health insurance.

Most of the medically bankrupt were solidly middle class before financial disaster hit. More than sixty percent of them had attended college and 66.4% had owned a home; 20% of families included a military veteran or active duty soldier. In many cases, high medical bills coincided with a loss of income as illness forced breadwinners to lose time from work. Often illness led to job loss, and with it the loss of health insurance.

Surprisingly, most of those bankrupted by medical problems had health insurance. More than three-quarters (77.9 percent) were insured at the start of the bankrupting illness, including 60.3 percent who had private coverage. By comparison, 80% of the non-elderly adult population and 85% of the entire U.S. population had health insurance in 2007. Hence, it appears that health insurance offers little protection against medical bankruptcy.

At the time of their filing, 69% of debtor families had coverage, and 60% of families had maintained continuous coverage for all family members. Yet even apparently well-insured families with continuous coverage faced ruinous out-of-pocket medical costs for co-payments, deductibles and uncovered services such as physical therapy, mental health care, and home care.

Providing coverage is not enough. Private health insurance is a defective consumer product, and neither private insurance, nor a public plan option that imitate private insurance can protect American families from bankruptcy. In order to provide real financial security, health coverage must be continuous and comprehensive.

Individuals with diabetes and those with neurological disorders such as multiple sclerosis had the highest costs, an average of \$26,971 and \$34,167 respectively. Hospital bills were the largest

single expense for about half of all medically bankrupt families; prescription drugs were the largest expense for 18.6 percent. Among medical debtors, hospital bills were the largest medical expense for 48%, drug costs for 19%, doctors' bills for 15% and insurance premiums for 4%. In 38% of cases lost income due to illness was a factor.

Medically bankrupt families with private insurance reported medical bills that averaged \$17,749 vs. \$26,971 for the uninsured. Most of those who lost coverage lost it because they lost their jobs or otherwise became unable to pay their premiums. Hence regulations to prohibit insurance companies from cancelling coverage for medical reasons would NOT have prevented most of these bankruptcies.

We were also able to take a preliminary look at the subsample of our 2007 bankrupt respondents who lived in the state of Massachusetts. Massachusetts had only 5.4% uninsured in 2007. Somewhat surprisingly, the share of personal bankruptcies related to medical illness and medical bills was no different than our national result. That is, about 3 out of every 5 bankruptcies in Massachusetts - as elsewhere in the nation - occurred in the wake of illness. Although we are currently looking at a larger sample of bankruptcy filers in Massachusetts, the preliminary findings from our 2007 data indicate that a Massachusetts-style reform will not protect middle-class Americans from medical bankruptcy.

Unfortunately, Massachusetts-style reform has not made health care affordable for middle class families. Our individual mandate forces middle-income residents to purchase private insurance or pay a fine of about \$1000. Yet the cheapest coverage available to a 56 year old (according to the state's Connector website) forces her to lay out \$4900 for a policy with a \$2,000 deductible before it pays for any care, and a 20% co-payment after that. Skimpy, overpriced coverage like that would not have protected the families in our survey from bankruptcy.

It is not surprising that one in six Massachusetts residents reported that they were unable to pay their medical bills last year. Access to an insurance policy is not the same thing as access to health care. An insurance policy with unaffordable deductibles, co-payments and the like may protect hospitals by assuring that at least part of each hospital bill gets paid, but it won't protect families. Even among Massachusetts residents WITH health insurance, 18% skipped care because they couldn't afford it. In the first year of Massachusetts' reform the state expanded Medicaid and Medicaid-like subsidized coverage and access improved, albeit at enormous cost to the state and federal governments. In the second year of the reform, access to health care in Massachusetts has actually deteriorated.

There is considerable controversy over the definition of medical bankruptcy, given the complexity of the financial problems many American families face. Families characterize their problems differently. Someone may mortgage a home to pay for surgery, and then be unable to pay off the mortgage, describing the reason for filing bankruptcy as "unable to pay the mortgage." Similarly, some people explain that they have lost too much time from work when they have taken off to care for a child who has been hospitalized. We believe that multiple ways of asking about medical bankruptcies give the most complete picture, but we publish the

breakdown in responses so that any other researcher or commentator can draw his or her own conclusions.

To help other researchers who might choose to use different definitions, we have supplied a detailed analysis of debtors who:

- Specifically identified medical problem of the debtor or spouse (32.1%) or another family member (10.8%) as a reason for filing bankruptcy.
- Specifically said medical bills were a reason for bankruptcy. (29.0%)
- 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. (40.3%)
- Mortgaged their homes to pay medical bills. (5.7%)
- Spent more than \$5000 or 10% of annual household income in out-of-pocket medical bills (34.7%)
- Total, one or more of the above criteria: 62.1%

The vast majority (92%) of bankruptcies that we classified as medical had medical bill problems as indicated by: listing medical bills as a specific reason for their bankruptcy, or having medical bills over \$5000 or 10% of household income, or that forced them to mortgage their home. The remaining 8% whose bankruptcy was classified as “medical” indicated that a medical problem or income loss due to illness was a cause of bankruptcy.

Ours is the only study based on direct surveys and interviews with a large sample of families filing for bankruptcy. Others have based their findings on bankruptcy court records alone (with no direct surveys or interviews) or on surveys of the general public that inquire about bankruptcy filings. Court records fail to identify medical bankruptcies because many medical bills are charged to credit cards and hence cannot be identified as “medical” in court records. Similarly, when medical providers turn debts over to collection agencies they would not appear on court documents as “medical.” Moreover, one cannot study bankruptcy by phone surveys or other population-based methods. Because bankruptcy carries a substantial stigma, about half of all respondents who are bankrupt deny that fact. As a result, surveys of the general public are an unreliable source of information on medical bankruptcy.

Subsequent to the 2001 study, Congress made it harder to file for bankruptcy, causing a sharp drop in filings. However, personal bankruptcy filings have soared as the economy has soured. In May 2009, more than 5,000 families filed for bankruptcy every business day. For all of 2009, the total is expected to reach about 1.4 million. The average personal bankruptcy involves 2.71 debtors and dependents. In total, an estimated 3.8 million Americans will be involved in personal bankruptcy filings this year. Based on the current bankruptcy filing rate, we predict that medical bankruptcies will total 866,000 and involve 2.346 million Americans this year – about one person every 15 seconds.

Medical bankruptcy is uncommon in countries with national health insurance. For instance, one study found that only 14.3% of Canadian bankruptcies are due to “health/misfortune” (a category that includes non-medical problems).

Our findings are frightening. Unless you’re Bill and Melinda Gates, your family is just one serious illness away from bankruptcy. For middle-class Americans, health insurance offers little protection. Most of us have policies with so many loopholes, co-payments and deductibles that illness can put you in the poorhouse. And even the best job-based health insurance often vanishes when prolonged illness causes job loss – precisely when families need it most. Private health insurance is a defective product, akin to an umbrella that melts in the rain.

We need to rethink health reform. Getting everyone a private insurance policy is not a solution. Reform also needs to help families who already have insurance by upgrading their coverage and assuring that they never lose it. Only single-payer national health insurance can make universal, comprehensive coverage affordable by saving the hundreds of billions we now waste on insurance overhead and bureaucracy. Unfortunately, insurance firms are pushing hard to keep themselves and their defective insurance policies at the core of our system. Reforms that expand this phony insurance - stripped-down plans riddled with co-payments, deductibles and exclusions – won’t stem the rising tide of medical bankruptcy.

A copy of the study is available at http://pnhp.org/new_bankruptcy_study or through the American Journal of Medicine, ajmmedia@elsevier.com, 212-633-3944.

CLINICAL RESEARCH STUDY

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Medical Bankruptcy in the United States, 2007: Results of a National Study

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ABSTRACT

BACKGROUND: Our 2001 study in 5 states found that medical problems contributed to at least 46.2% of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened.

METHODS: We surveyed a random national sample of 2314 bankruptcy filers in 2007, abstracted their court records, and interviewed 1032 of them. We designated bankruptcies as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

RESULTS: Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over \$5000, or 10% of pretax family income. The test case criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6%. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001.

CONCLUSIONS: Illness and medical bills contribute to a large and increasing share of US bankruptcies.

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KEYWORDS: Bankruptcy; Health care costs; Health economics

As recently as 1981, only 8% of families filing for bankruptcy did so in the aftermath of a serious medical problem.¹ By contrast, our 2001 study in 5 states found that illness or medical bills contributed to about half of bankruptcies.²

Since then, the number of un- and underinsured Americans has grown;³ health costs have increased; and Congress tightened the bankruptcy laws.⁴

Here we report the first-ever national random-sample survey of bankruptcy filers.

METHODS

We used 3 data sources: questionnaires mailed to debtors immediately after bankruptcy filing; court records; and telephone interviews with a sub-sample of debtors.

Sample Design

Between January 25 and April 11, 2007, we obtained from Automated Access to Court Electronic Records, a list of all 118,308 bankruptcy petitions filed in the US. We excluded filings in Guam and Puerto Rico, nonpersonal bankruptcies, and cases missing a name or address. Within 2 weeks of their filings, we mailed introductory letters to 5251 randomly selected debtors; 275 were returned as undeliverable. We then mailed self-administered questionnaires to the 4976 debtors with valid addresses; 2314 (46.5%) were completed and returned; 124 were returned incomplete (2.5%) and 83 (1.7%) declined to participate; 2455 (49.3% of those with valid addresses) did not respond.

We compared court records (described below) of respondents with a random sample of 99 nonrespondents. Nonre-

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spondents resembled respondents in income, assets, debts, net worth, market value of homes, and history of prior bankruptcy.

Questionnaire

Introductory letters described the study and offered debtors the option of obtaining a Spanish-language version of the questionnaire. The questionnaire and S2 were mailed a few days later. Non-respondents received replacement questionnaires, another S2, and were invited to respond via telephone or on-line. Subsequently, we offered nonrespondents \$50 to complete the questionnaire.

The questionnaire asked about demographics, health insurance and gaps in coverage, occupation, employment, housing, and efforts to cope financially before filing. It also asked about specific reasons for filing for bankruptcy; the range of out-of-pocket medical expense (none, \$1-\$999, \$1000-\$5000, or >\$5000); loss of work-related income; and borrowing to pay medical bills. Finally, it asked respondents if, for \$50, they would be willing to complete a follow-up interview.

Court Records

We obtained the public bankruptcy court records of respondents and the sample of nonrespondents from the federal court's electronic filing system. Research assistants (mainly law students) abstracted each record.

The court records included the chapter of filing, income, assets, and debts outstanding at the time of filing. These records indicate the creditor to whom money is owed, but not why the debt was incurred.

Telephone Interviews

There were 2314 debtors who completed questionnaires, 2007 of whom were willing to be interviewed. By February 2008, research assistants had completed telephone interviews (in English or Spanish) with 1032 of them; 69 debtors no longer wished to be interviewed. We were unable to reach 906.

Interviewers collected additional detail about employment, finances, housing, borrowing to pay medical bills, and whether medical bills or income loss due to illness had contributed to their bankruptcy (questions we used to verify written questionnaire responses from the entire sample of 2314 debtors).

The 1032 telephone interviews identified 639 patients (debtors or dependents) whose health problems contributed to bankruptcy; details about medical expenses, health insur-

ance, and diagnoses were obtained. Two physicians grouped diagnoses into 14 categories.

Telephone survey participants resembled other respondents on most financial and demographic characteristics. They were slightly older and better educated.

CLINICAL SIGNIFICANCE

- 62.1% of all bankruptcies have a medical cause.
- Most medical debtors were well educated and middle class; three quarters had health insurance.
- The share of bankruptcies attributable to medical problems rose by 50% between 2001 and 2007.

Data Analysis

We used data from the questionnaires and court records to analyze demographics, health insurance coverage at the time of filing, and gaps in coverage.

The questionnaires were the basis for our 2001-2007 time trend analysis. For this analysis, we replicated the most conservative definition employed in the 2001 study, which designated as "medically bankrupt" debtors citing illness or medical bills as a specific reason for bankruptcy; OR report-

ing uncovered medical bills >\$1000 in the past 2 years; OR who lost at least 2 weeks of work-related income due to illness/injury; OR who mortgaged a home to pay medical bills. Debtors who gave no answers regarding reasons for their bankruptcy were excluded from analyses.

For all other analyses (ie, those not reporting time trends) we adopted a definition of medical bankruptcy that utilizes the more detailed 2007 data. We altered the 2001 criteria to include debtors who had been forced to quit work due to illness or injury. We also reconsidered the question of how large out-of-pocket medical expenses should be before those debts should be considered contributors to the family's bankruptcy. Although we needed to use the threshold of \$1000 in out-of-pocket medical bills for consistency in the time trend analyses, we adopted a more conservative threshold—\$5000 or 10% of household income—for all other analyses. Adopting these more conservative criteria reduced the estimate of the proportion of bankruptcies due to illness or medical bills by 7 percentage points.

To arrive at nationally representative estimates, we weighted the data to adjust for the slight underrepresentation of respondents who filed under Chapter 13 (bankruptcies with repayment plans). In calculating mean out-of-pocket medical expenses from our telephone interviews, we trimmed outliers at \$100,000.

Chi-squared and 2-tailed *t* tests were used for univariate analyses. We used forward stepwise logistic regression analysis on the 2007 cohort to assess predictors of medical bankruptcy and predictors of home loss or foreclosure among homeowners. Finally, we performed logistic regression using the combined 2001 and 2007 cohorts to examine whether the odds of a bankruptcy being medical were higher in 2007 than in 2001, after controlling for demographics, income, and insurance status. SAS Version 9.1 (SAS Institute Inc., Cary, NC) was used for all analyses.

Table 1 Demographic Characteristics of 2314 Bankruptcy Filers and Comparison of Medical and Nonmedical Filers, 2007*

	All Bankruptcies	Medical Bankruptcies	Nonmedical Bankruptcies	P Value Medical vs Nonmedical Bankruptcies
Mean age	44.4 years	44.9 years	43.3 years	.01
Debtor or spouse/partner male	44.5%	44.9%	44.3%	NS
Married	43.9%	46.3%	40.1%	.02
Mean family size—debtors + dependents	2.71	2.79	2.63	.02
Attended college	61.9%	60.3%	65.8%	.02
Homeowner or lost home within 5 years	66.7%	66.4%	67.8%	NS
Current homeowner	52.3%	52.0%	53.2%	NS
Occupational prestige score >20	87.3%	86.1%	89.8%	.01
Mean (median) monthly household income at time of bankruptcy filing	\$2676 (\$2299)	\$2586 (\$2225)	\$2851 (\$2478)	.002
Debtor or spouse/partner currently employed	79.2%	75.5%	85.0%	.001
Debtor or spouse/partner active duty military or veteran	19.4%	20.1%	18.4%	NS
Market value of home (mean)	\$147,776	\$141,861	\$159,145	.03
Mean net worth (assets—debts)	—\$41,474	—\$44,622	—\$37,650	NS

*Bankruptcies meeting at least one of the following criteria: illness, injury or medical bills listed as specific reason for filing OR uncovered medical bills >\$5000 or >10% of annual family income OR, lost ≥2 weeks of work-related income due to illness/injury, OR depleted home equity to pay medical bills.

Human subject committees at Harvard Law School and The Cambridge Health Alliance approved the project.

RESULTS

The demographic characteristics of our sample are shown in Table 1. Most debtors were middle aged, middle class (by occupational prestige),⁵ and had gone to college. Their modest incomes reflect the financial setbacks common in the peri-bankruptcy period. Two thirds were homeowners.

Compared with other debtors, medical debtors had slightly lower incomes, educational attainment, and occupational prestige scores; more were married and fewer were employed (reflecting more disability). Medical debtors were older and had larger families. Although similar proportions were homeowners, medical debtors' homes had 11% lower market value. The average net worth was similar (and negative) for medical and nonmedical debtors (—\$44,622 vs —\$37,650, $P > .05$).

Medical Causes of Bankruptcy

Illness or medical bills contributed to 62.1% of all bankruptcies in 2007 (Table 2).

Unaffordable medical bills and income shortfalls due to illness were common; 57.1% of the entire sample (92% of the medically bankrupt) had high medical bills, proportions that did not vary by insurance status; 5.7% of homeowners had mortgaged their homes to pay medical bills; 40.3% of the entire sample had lost income due to illness; 95% of the lost-income debtors also had high medical bills.

Data from the detailed telephone survey yielded confirmatory results. When asked about problems that contributed very much or somewhat to their bankruptcy, 41.8% of interviewees specifically identified a health problem, 54.9%

cited medical or drug costs, and 37.8% blamed income loss due to illness. Overall, 68.8% cited at least one of these medical causes. An additional 6.8% had recently borrowed money to pay medical bills.

Insurance Status of Debtors and Dependents

Less than one quarter of debtors—whether medical or non-medical—were uninsured when they filed for bankruptcy; an additional 7% had uninsured family members (Table 3). Medically bankrupted families, however, had more often experienced a lapse in coverage during the 2 years before filing (40.0% vs 34.1%, $P = .005$).

Table 2 Medical Causes of Bankruptcy, 2007*

	Percent of All Bankruptcies
Debtor said medical bills were reason for bankruptcy	29.0%
Medical bills >\$5000 or >10% of annual family income	34.7%
Mortgaged home to pay medical bills	5.7%
Medical bill problems (any of above 3)	57.1%
Debtor or spouse lost ≥2 weeks of income due to illness or became completely disabled	38.2%
Debtor or spouse lost ≥2 weeks of income to care for ill family member	6.8%
Income loss due to illness (either of above 2)	40.3%
Debtor said medical problem of self or spouse was reason for bankruptcy	32.1%
Debtor said medical problem of other family member was reason for bankruptcy	10.8%
Any of above	62.1%

*Percentage based on recent homeowners rather than all debtors.

Table 3 Health Insurance Status of Debtor Households With and Without Medical Causes of Bankruptcy

	Medical Bankruptcy	Nonmedical Bankruptcy	P Value
Debtor or a dependent uninsured at time of bankruptcy filing	30.8%	30.7%	.93
Debtor or a dependent had a lapse in coverage during 2 years before bankruptcy filing	40.0%	34.1%	.005

In multivariate analysis, being uninsured at filing did not predict a medical cause of bankruptcy, while a gap in coverage did (odds ratio [OR] = 1.35, $P = .002$). Other predictors included: older age (OR = 1.016/year, $P = .0001$), married (OR = 1.59, $P = .0001$), female (OR = 1.34, $P = .002$), larger household (OR = 1.97/household member, $P = .01$), and lower income quartile (OR = 1.30, $P = .0001$).

Medical debtors' court records identified more debt owed directly to doctors and hospitals than did nonmedical debtors', a mean of \$4988 vs \$256, respectively ($P < .0001$). Medical debtors with coverage gaps owed providers a mean of \$8338, vs \$2740 ($P < .0001$) for medical debtors with continuous coverage. Nonmedical debtors had few medical debts, averaging under \$300 regardless of insurance status. (Medical debts financed through credit cards or other borrowing, or owed to collection agencies are not included because they cannot be identified through court records.)

Patients Whose Illness Contributed to Bankruptcy

Telephone interviews identified 639 patients whose illness contributed to bankruptcy: the debtor or spouse in 77.9% of cases; a child in 14.6%; and a parent, sibling or other adult in 7.5%. At illness onset, 77.9% were insured; 60.3% had private insurance as their primary coverage; 10.2% had Medicare; 5.4% had Medicaid; and 2% had Veterans Affairs/military coverage. Few of the uninsured lacked coverage because of a preexisting condition (2.8%) or belief that coverage was unnecessary (0.3%); nearly all cited economic reasons.

By the time of bankruptcy, the proportion of patients with private coverage had fallen to 54.1%, while the percentage with Medicare and Medicaid had increased to 16.4% and 9.9%, respectively. The proportion whose employers contributed to coverage decreased from 43.2% to 36.6%.

Out-of-pocket medical costs averaged \$17,943 for all medically bankrupt families; \$26,971 for uninsured patients, \$17,749 for those with private insurance at the outset, \$14,633 for those with Medicaid, \$12,021 for those with Medicare, and \$6545 for those with Veterans Affairs/military

coverage. For patients who initially had private coverage but lost it, the family's out-of-pocket expenses averaged \$22,568.

Among common diagnoses, nonstroke neurologic illnesses such as multiple sclerosis were associated with the highest out-of-pocket expenditures (mean \$34,167), followed by diabetes (\$26,971), injuries (\$25,096), stroke (\$23,380), mental illnesses (\$23,178), and heart disease (\$21,955).

Hospital bills were the largest single out-of-pocket expense for 48.0% of patients, prescription drugs for 18.6%, doctors' bills for 15.1%, and premiums for 4.1%. The remainder cited expenses such as medical equipment and nursing homes. While hospital costs loomed largest for all diagnostic groups, for about one third of patients with pulmonary, cardiac, or psychiatric illnesses, prescription drugs were the largest expense.

Our telephone interviews indicated the severity of job problems caused by illness. In 37.9% of patients' families, someone had lost or quit a job because of the medical event; 24.4% had been fired, and 37.1% subsequently regained employment. In 19.9% of families suffering a job loss, the job loser was a caregiver.

Changes in Medical Bankruptcy, 2001 to 2007

In our 2007 study, 69.1% of the debtors met the legacy definition of medical bankruptcy employed in our 2001 study, a 22.9 percentage point absolute increase (49.6% relative increase) from 2001, when 46.2% met this definition ($P < .0001$). (Inflation, which might edge families over our \$1000 medical debt threshold, did not account for this change. An analysis that used all criteria except the size of medical debts found a 48.7% relative increase. An analysis limited to the 5 states in our 2001 study yielded virtually identical findings.)

In multivariate analysis, a medical cause of bankruptcy was more likely in 2007 than in 2001 (OR = 2.38, $P < .0001$) (Table 4).

DISCUSSION

In 2007, before the current economic downturn, an American family filed for bankruptcy in the aftermath of illness every 90 seconds; three quarters of them were insured.

Since 2001, the proportion of all bankruptcies attributable to medical problems has increased by 50%. Nearly two thirds of all bankruptcies are now linked to illness.

How did medical problems propel so many middle-class, insured Americans toward bankruptcy? For 92% of the medically bankrupt, high medical bills directly contributed to their bankruptcy. Many families with continuous coverage found themselves under-insured, responsible for thousands of dollars in out-of-pocket costs. Others had private coverage but lost it when they became too sick to work. Nationally, a quarter of firms cancel coverage immediately when an employee suffers a disabling illness; another quar-

Table 4 Multivariate Predictors of Medical Causes of Bankruptcy, 2001 and 2007 Combined

	Odds Ratio	95% Confidence Interval	P Value
Age	1.02	1.01-1.02	.0001
Married	1.32	1.13-1.55	.0006
Own home now or in past 5 years	1.10	0.93-1.30	NS
All family members insured at time of filing	1.23	1.03-1.46	.02
Gap in health insurance coverage for any family member within past 2 years	1.64	1.38-1.94	.0001
Income quartile	.99	.82-1.07	NS
Attended college	1.02	.87-1.18	NS
Year of bankruptcy filing, 2007 vs 2001	2.38	2.05-2.77	.0001

ter do so within a year.⁶ Income loss due to illness also was common, but nearly always coupled with high medical bills.

The present study and our 2001 analysis provide the only data on large cohorts of bankruptcy filers derived from in-depth surveys. As with any survey, we depend on respondents' candor. However, we also had independent checks—from court records filed under penalty of perjury—on many responses. Because questionnaires and court records were available for our entire sample, we used them for most calculations. The lowest plausible estimate of the medical bankruptcy rate from these sources is 44.4%—the proportion who directly said that either illness or medical bills were a reason for bankruptcy. But many others gave reasons such as “aggressive collection efforts” or “lost income due to illness” and had large medical debts. Indeed, detailed telephone interview data available for 1032 debtors revealed an even higher rate of medical bankruptcy than our 62.1% estimate—at least 68.8% of all filers.

Our current methods address concerns expressed about our previous survey. We assembled a random, national sample and asked far more detailed questions. In addition, we adopted more stringent criteria for medical bankruptcy. Adopting an even more stringent threshold for medical debts (eg, eliminating those with medical debts below 10% of family income) would reduce our estimate by <1%.

Teasing causation from cross-sectional data is challenging. Multiple factors push families into bankruptcy. Yet, our data clearly establish that illness and medical bills play an important role in a large and growing proportion of bankruptcies.

Changes in the Law

Between our 2001 and 2007 surveys, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which instituted an income screen and procedural barriers that made filing more difficult and expensive.

The number of filings spiked in mid-2005 in anticipation of the new law, then plummeted. Since then, filings have increased each quarter. They are likely to exceed one million households in 2008, representing about 2.7 million people.

BAPCPA's effects appear nonselective. Current filers differ from past ones mainly in having struggled longer with their debts.⁷ New restrictions fall equally on medical and nonmedical bankruptcies, with no preferences for medical debts or sick debtors. It is implausible to ascribe the growing predominance of medical causes of bankruptcy to BAPCPA.

Conversely, there is ample evidence that the financial burden of illness is increasing. The number of under-insured increased from 15.6 million in 2003 to 25.2 million in 2007.⁸ Of low- and middle-income households with credit card balances, 29% use credit card borrowing to pay off medical expenses over time.⁸ Collection agencies contacted 37.2 million Americans about medical bills in 2003.⁹ Between 2005 and 2007, the proportion of nonelderly adults reporting medical debts or problems paying medical bills rose from 34% to 41%.¹⁰

Adding to Other Studies

We have reviewed elsewhere the older studies on medical bankruptcy.^{2,11} Most rely exclusively on court records where many medical debts are invisible, disguised as credit card debt or mortgages. In our cohort, most medical debtors had charged unaffordable medical care to credit cards.

Similarly, debts turned over to collection agencies by doctors or hospitals may be unrecognizable on court records. Moreover, income loss due to illness cannot be identified. In short, even though such studies find substantial rates of medical bankruptcy,^{12,13} estimates based solely on court records understate medical bankruptcies.⁹

Population-based studies also are problematic because many debtors are unwilling to admit to filing. Thus, a study based on the Panel Study of Income Dynamics could identify only 74 bankruptcies (0.4% of respondents), half the actual filing rate among the national population from which the sample was drawn.¹³

A few studies employed novel methods to analyze medical bankruptcy. One found a high bankruptcy filing rate in a cohort of patients with serious neurologic injuries.¹⁴ A survey of cancer patients documented a 3% bankruptcy rate; 7% had taken a second mortgage to pay for treatments.¹⁵ A questionnaire-based study found medical contributors to 61% of Utah bankruptcies; 58% of families seeking help at bankruptcy clinics in upstate New York reported outstanding medical debts.¹⁶

Medical impoverishment, although common in poor nations,^{17,18} is almost unheard of in wealthy countries other than the US.¹⁹ 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 fre-

quently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones.

ACKNOWLEDGMENTS

Additional support came from Harvard Law School and the American Association of Retired Persons. Professors Melissa Jacoby, Robert Lawless, Angela Littwin, Katherine Porter, John Pottow, and Teresa Sullivan played key roles in the Consumer Bankruptcy Project.

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ATTACHMENT 2

Medical Bankruptcy – Q&A

David U. Himmelstein, M.D., Deborah Thorne, Ph.D., Elizabeth Warren, J.D., Steffie Woolhandler, M.D., M.P.H.

1- What is a “medical bankruptcy”?

A number of medical factors can contribute to a family’s financial collapse, including high medical bills or lost time from work. Because different researchers use different definitions, we supplied a detailed analysis of debtors who:

- Specifically identified medical problem of the debtor or spouse (32.1%) or another family member (10.8%) as a reason for filing bankruptcy.
- Specifically said medical bills were a reason for bankruptcy. (29.0%)
- 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. (40.3%)
- Mortgaged their homes to pay medical bills. (5.7%)
- Spent more than \$5,000 or 10% of annual household income in out-of-pocket medical bills (34.7%)
- Total, one or more of the above criteria: 62.1%

The vast majority (92%) of bankruptcies that we classified as medical had medical bill problems as indicated by: listing medical bills as a specific reason for their bankruptcy; or having medical bills of bills \$5,000 or 10% of household income or that forced them to mortgage their home. The remaining 8% whose bankruptcy was classified as “medical” indicated that a medical problem or income loss due to illness was a cause of bankruptcy.

2- Why do only 29% of bankrupt people identify medical bills as a reason for filing bankruptcy, but you say the total percentage of medical bankruptcies is 62.1%?

Families characterize their problems differently. Someone may mortgage a home to pay for surgery, then be unable to pay off the mortgage, describing the reason for filing bankruptcy as “unable to pay the mortgage.” Similarly, some people explain that they have lost too much time from work when they have taken off to care for a child who has been hospitalized. We believe that multiple ways of asking about medical bankruptcies give the most complete picture, but we publish the breakdown in responses so that any other research or commentator can draw his or her own conclusions.

Finally, it should be noted that many people who are financially ruined by illness are undoubtedly too ill, too poor or demoralized to pursue formal bankruptcy, and are not counted in our study.

3- What is the impact of health insurance?

More than three-quarters (78%) of the families that met the criteria for medical bankruptcy had health insurance at the onset of their illness or accident. By comparison, 80% of the non-elderly adult population and 85% of the entire U.S. population had health insurance in 2007. Hence, it appears that health insurance offers only modest protection against medical bankruptcy.

4- Is the problem of medical bankruptcies just because of the recession?

No. The families in this study filed for bankruptcy between January-April of 2007, before the recession began. Since then, the financial stress on families has grown.

5- Is this a national sample of all families filing for bankruptcy?

Yes. The sample was drawn from bankruptcy filings across the country.

6- How did you get your information?

We contacted a random sample of all personal bankruptcy filers in the U.S. during the winter of 2007. Written questionnaires were returned by 2,314 debtors, and we also analyzed their bankruptcy court records. We also carried out extensive telephone interviews with 1,032 of these debtors.

Finally, to be sure that the debtors who returned our survey were similar to those who did not, we also analyzed the court records of 99 of the non-respondents. They were almost identical to those who returned the survey in terms of debts, income, assets and other characteristics.

7- What's the basis for saying that the proportion of bankruptcies that are medical rose by 50% between 2001 and 2007?

In order to compare the medical bankruptcy rates in 2007 and in our 2001 study we had to use the same definitions in both years. Our 2001 study had used a less stringent ("legacy") definition of medical bankruptcy that included families with more than \$1000 in unpaid medical bills. Using this "legacy" definition, the medical bankruptcy rate rose from 46.2% in 2001 to 69.1% in 2007 – a 49.6% increase. The 2001 estimate relied on data collected from bankruptcy filers in five states. Analysis of the 2007 data confirmed that the five states included in the 2001 survey also saw a 50% increase in medical bankruptcies.

8- Would health reform eliminate the problem of medical bankruptcy?

Many debtors described a complex web of problems involving illness, work, and family. Separating medical from other causes of bankruptcy is difficult. Hence, we cannot presume that eliminating the medical antecedents of bankruptcy would have prevented all of the filings we classified as “medical bankruptcies.” The high rate of insurance among the medical bankrupts suggests that any health reform that fails to improve existing private coverage is unlikely to make a major impact on medical bankruptcy. Moreover, our data also highlight the need for improved disability coverage.

9- Why do some others claim that medical bankruptcy rates are much lower?

Ours is the only study based on direct surveys and interviews with a large sample of families filing for bankruptcy. Others have based their findings on bankruptcy court records alone (with no direct surveys or interviews) or on surveys of the general public that inquire about bankruptcy filings. Court records fail to identify medical bankruptcies because many medical bills are charged to credit cards and hence cannot be identified as “medical” in court records. Similarly, when medical providers turn debts over to collection agencies they would not appear as “medical.” Because bankruptcy carries a substantial stigma, about half of all respondents who are bankrupt deny that fact. As a result, surveys of the general public are an unreliable source of information on medical bankruptcy. For these reasons, the only way to accurately assess medical bankruptcy is to directly survey families who file for bankruptcy.

Mr. COHEN. Thank you for your testimony. [Applause.]
We will not have applause, except for the Chairman, please.
Thank you for your testimony, Dr. Woolhandler.

Our third witness is Aparna Mathur, Dr. Aparna Mathur. Dr. Mathur is an economist who writes about taxes and wages, and she has also been a consultant to the World Bank and taught economics at the University of Maryland.

Her work ranges from research on carbon taxes and the impact of state health insurance mandates on small firms to labor market outcomes. Her research on corporate taxation includes the widely discussed co-authored 2006 “wages and taxes” paper, which explored the link between corporate taxes and manufacturing wages.

Thank you, Dr. Mathur. Will you please proceed with your testimony?

**TESTIMONY OF APARNA MATHUR, Ph.D., RESEARCH FELLOW,
AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY
RESEARCH**

Ms. MATHUR. Thank you. Chairman Conyers, Ranking Member Frank and distinguished Members, thank you for giving me the opportunity to testify today.

In my testimony, I will explore the extent to which household medical debts can be held responsible for consumer bankruptcy filings. In recent times, the debate surrounding the topic has become particularly heated, with studies claiming that more than 60 percent of all bankruptcies are medical bankruptcies.

While sympathetic to the plight of these families in tough economic times, I believe that to positively inform and steer the debate, we need to disentangle the rhetoric from the facts.

My own analysis of microdata from nationally representative data sets covering thousands of American families over several years has led me to conclude that the extent of the problem is being overstated and therefore misdiagnosed.

A rise in medical bankruptcies should show up in the data as a rise in medical debts. The most extensive nationally representative data on medical debts is available from the Survey of Consumer Finances. This data shows that medical indebtedness has actually declined between 1989 and 2004.

The number of families reporting any medical debt has declined from about 5 percent in 1989 to about 3 percent in 2004. At the same time, medical debt as a fraction of all debts have declined from 0.6 percent in 1989 to 0.3 percent in 2004.

Even if you focus on the latter half of this decade, the same data show that there has been no significant change in medical debts, though credit card debts have risen over this period. Therefore, while indebtedness in general may be a problem, medical indebtedness per se is not.

Other surveys linking medical debts and bankruptcies reach similar conclusions. The Department of Justice’s Executive Office of the United States Trustee examined the records of approximately 5,000 bankruptcy cases filed between 2000 and 2002. More than 50 percent of the cases listed no medical debt. In only 10 percent of the cases was medical debt higher than \$5,000.

So there are very few cases in which medical debts can be held responsible for the bankruptcy filing.

The Panel Study of Income Dynamics, another household survey, similarly shows that medical debts account for 9 to 16 percent of all bankruptcies.

Survey data, however, need to be interpreted with caution. In order to draw the right inferences, we need to apply the correct methodology to the survey data. Using more rigorous multivariate

regression analysis in an AEI paper that I wrote, I still 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 who also incur medical debts. This was also the conclusion of a 1999 study by Domowitz and Robert Sartain in the *Journal of Finance*.

Accounting for prevalence of various sources of debt, they found that the largest single contribution to bankruptcy at the margin is credit card debt, and they distinguish between medical and credit card debt.

In general, the economics literature reviewed in my longer testimony using standard regression analysis to account for household and macroeconomic conditions that could influence the filing has typically found that medical debts are not the most important cause of bankruptcy filings.

So why do the Himmelstein and colleague surveys conclude that nearly 62 percent of filings are medically-related? There are several reasons listed in my longer written testimony. I will talk about a couple of those here.

First, Table 2 of the study clearly states that only 29 percent of the respondents believe 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 \$5,000 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 medical costs.

Second, if the authors are trying to establish whether medical debts cause bankruptcy filings, at the very least the appropriate sample should have included households with and without medical debt and households who filed or did not file for bankruptcy.

Having defined the appropriate sample, then the correct methodology, which is widely used in the economics literature, 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. What the authors have established is some correlation of medical debts and bankruptcies but not causation.

Having said that, however, I do not wish to underestimate the serious effects of medical problems on particular families. Rising health care costs are clearly an area of growing concern, and there is an urgent need to tackle the issue.

At the same time, we should recognize that families are being pushed to the brink of bankruptcy for a multitude of reasons.

While some recent reports based on different methods would have us believe that rising health care costs are, in fact, the main factor responsible for household bankruptcies, I hope my testimony has provided a more substantial basis for concluding that this is not the case.

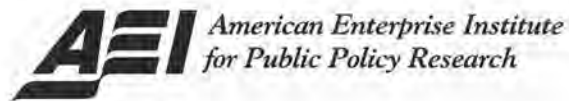
The most effective solution to the problem of rising bankruptcies in these tough economic times is to help families keep their jobs, retain their earning power, stay in their homes and live within their means.

If economic problems nevertheless become unmanageable, the bankruptcy system is designed precisely to give families a fresh start by discharging some of their debt.

If you mistakenly focus too narrowly and simply on medical indebtedness, believing it to be a bigger problem than it is, we will be even further away from the solution we need. Thank you.

[The prepared statement of Ms. Mathur follows:]

PREPARED STATEMENT OF APARNA MATHUR



Statement before the United States House of Representatives
Committee on the Judiciary
Subcommittee on Commercial and Administrative Law
Hearing on "Medical Debt: Is Our Healthcare System Bankrupting Americans?"

Medical Debts and Bankruptcy Filings

Aparna Mathur
Research Fellow
American Enterprise Institute

Tuesday, July 28, 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;

In my testimony today, I will explore the extent to which household medical debts can be held responsible for consumer bankruptcy filings. This is an issue of tremendous concern 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. In recent times, the debate surrounding the topic has become particularly heated with studies claiming that more than 50 percent of all personal bankruptcy filings are caused by rising medical debt. This is obviously an emotional issue and anecdotal evidence of the hardship suffered by families struggling with medical bills and loss of jobs is hard to ignore. While sympathetic to the plight of these families in tough economic times, I believe that to positively inform and steer the debate, we need to disentangle the rhetoric from the facts. My own analysis of micro data from nationally representative datasets covering thousands of American families over several years has led me to conclude that the extent of the problem is being overstated and therefore misdiagnosed. A flawed understanding of the problem will inevitably lead us to the wrong solution.

The American Bankruptcy Institute provides statistics on consumer bankruptcy filings for the U.S. for several years.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.

¹ <http://www.abiworld.org/AM/AMTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=57826>

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 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. Medical debts have risen marginally from 5.5 percent of all debt in 2001 to 5.8 percent in 2007. 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 2004.³ 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.

II. What Explains Consumer Bankruptcy Filings?

There is a fairly large economics literature relating to the household personal bankruptcy decision. Very few of the papers however, find medical problems or medical debt as significant explanatory variables causing bankruptcies.

In the literature, there are two views about consumer bankruptcy filings. The adverse events view suggests that sudden shocks to income in a situation of high consumer indebtedness

² <http://www.federalreserve.gov/pubs/oss/oss2/scfindex.html>

³ <http://www.iarw.org/papers/2008/bucks.pdf>

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.

The second is the strategic view. This emphasizes that households file for bankruptcy when the financial benefit from filing increases. Under Chapter 7 personal bankruptcy, debtors in the US 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. The 2005 surge in bankruptcy filings in anticipation of a change in the personal bankruptcy law supports the strategic view of bankruptcy since it appeared 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 the prediction that households are more likely to file when their financial benefit from filing is higher.⁴

Medical problems can lead to bankruptcy either directly through the accumulation of medical debt or indirectly through loss of work days and subsequent loss in earnings. There is little evidence in the literature to support the indirect effect of medical problems on bankruptcies. In the paper by Fay et al. (2002), health problems faced by the household head or spouse, spells of unemployment, and the household head being divorced in the previous year were not significant factors in explaining bankruptcy filings. A study by Jan Domowitz and Robert Sartin, also finds little correlation of medical debt with other sources of financial distress, such

⁴ Fay, Scott, Hurst, Erik and White, Michelle (2002), "The Household Bankruptcy Decision", *American Economic Review*, Vol. 92 No.3, June 2002, 706-718

as job loss or income interruption.⁵ In my own research, I find no evidence that the poor health of the household head could significantly raise the probability of a bankruptcy filing. A possible reason for this is that for the majority of cases, a substantial level of these indirect effects eventually should show up also as significant medical debts. To the extent that job losses occur as a result of a medical emergency, they can be considered to be the proximate cause of a bankruptcy filing only if the filing happens within a short period of time after the medical emergency. Job losses or lost weeks of work due to illness that occurred almost a year prior to the filing are unlikely to be significant predictors of bankruptcy filings since there may have been several other factors in the intermediate period that could be held responsible for the filing. Moreover, because we ultimately care most about the effect that rising healthcare costs have on families, it remains hard to justify how bankruptcies due to illnesses that lead to job losses are a direct consequence of rising healthcare costs alone.

In the next section, we therefore focus on the direct effect of medical bills on bankruptcy filings.

III. Medical Debts and Bankruptcy Filings

A. Evidence from Surveys

The evidence on the extent of medical debts in bankruptcy filings is fairly mixed. Most studies so far have relied on surveys of households or bankruptcy filers. While surveys provide relevant information, their results are not necessarily conclusive since they can be driven by the choice of sample (“sample selection” issues) such as whether the respondents involve bankruptcy filers or general households, whether respondents are married and their income, wealth and earnings status, as well as the sample size and the framing of questions which could bias the

⁵ Domowitz, Ian and Sartain, Robert (1999), “Determinants of the Consumer Bankruptcy Decision”, *Journal of Finance*, Vol. 54, No.1, Feb 1999, 403-420

results. These are discussed in a separate section with reference to the Himmelstein et al. (2005 and 2009) studies. In this section, we show how these issues lead to inconclusive estimates of medical bankruptcies based on survey data.

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 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. As mentioned earlier, lost weeks of work due to illness and other medical problems cannot be blamed on rising healthcare costs. Therefore, the number that we really care about is the number of bankruptcies actually caused by medical bills. The authors claim that this number is approximately 57 percent. As we discuss in the next section that critiques the methods used in the two studies, even this number is overstated. Moreover, this number is in stark contrast to findings reported by other surveys that rely on a larger sample size and a stricter definition of a medical bankruptcy.

The closest comparable survey to this 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

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

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. There were a few cases where extremely high medical debt likely explained the subsequent filing—one percent of cases accounted for 36.5% of medical debt and less than 10 percent of all cases represented 80% of all reported medical debt. Of the minority (46%) of cases in the sample with medical debt, the average medical debt was \$4,978 per case, 78.4 percent of those cases reported medical debts below \$5,000 (an average of \$1,212 for this group), and medical debts accounted for 13.0 percent of the total general unsecured debt for those reporting medical debt. Thus, even among those who reported medical debt, few reported medical debt levels sufficiently high to conclude that they were a primary cause of bankruptcy.

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 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. Illness and Injury

⁸ <http://psidonline.isr.umich.edu/>

accounted for only 6 percent of the filings. Therefore medical bills can be ascribed as the primary cause of the filing in only 9 percent of the cases. The number rises to 16 percent if we include all filings that claim medical bills as at least one of the causes of the filing. The most important cause appears to be credit card debt accounting for more than 50 percent of all filings.

Other surveys focus on a wider sample of all households rather than only households that filed for bankruptcy. For instance, a 2008 Report by the Center for Studying Health System Change shows that about 15 percent of families in 2003 and 19 percent in 2007 had problems paying medical bills. Of these, only about 20 percent actually considered filing for bankruptcy and an even smaller fraction actually did file for bankruptcy.⁹ A Kaiser Family Foundation Health Tracking Poll conducted in June 2009 found that 26 percent of respondents claimed that they had had problems paying medical bills in the previous year.¹⁰

B. Evidence Using Regression Analysis

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

⁹ <http://www.hschange.org/CONTENT/1017/#ib1>

¹⁰ <http://facts.kff.org/chart.aspx?ch=813>

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 Sartin 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 Sartin 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 1994.¹¹ The main aim in the paper was to test whether medical debts can be ascribed as the leading cause of bankruptcy filings. To this end, I first developed a classification of households into medical and other debtors. Then I regressed the probability of bankruptcy on medical (and other) debts using a probit model and a hazard model.

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. Altogether, a 10 percent increase in debts (as a fraction of income) of households with primarily credit card debts would cause bankruptcy filings to go up by 36 percent on average. A 10 percent increase in debts (as a fraction of income) of households with *primarily* medical debts would cause filings to go up by 27 percent on average.

What does this imply for current estimates of medical bankruptcies? The SCF shows that for all families, total debts as a fraction of income have increased by about 10 percent over the

¹¹ “Mathur, Apama (2006), “Medical Bills and Bankruptcy Filings,” AEI Working Paper
<http://www.aei.org/paper/24680>

period 2001-2007. Therefore, even if all of this increase was due to medical debts (which is not likely since credit card debts have been rising faster over this period), the additional bankruptcy filings due to medical debts should be approximately 27 percent of the total.

IV. 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.¹² 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.

V. Conclusion

To summarize, data from surveys, including the Himmelstein et al. studies, would suggest that by the respondents' own estimates, the fraction of bankruptcies caused by medical debts ranges from around 16 to 29 percent. The upper bound may be an overestimate since the respondents in the Himmelstein et al. survey also do not specify whether medical bills were the immediate cause or the most important cause of the filing. The only survey that asks the right questions is the PSID, which estimates that between 1984 and 1996, an average of about 16 percent of filings were due to medical bills. Given that "goods and services" debt, which includes medical debt, as a fraction of all debts has actually declined between 1998 and 2007

¹² Dranove, David and Millenson, Michael, L. (2006), "Medical Bankruptcy: Myth vs Fact" *HEALTH AFFAIRS* 74 (2006)

from 6 percent to 5.8 percent of all debt (SCF, 2007), it is hard to imagine that medical bankruptcies have increased tremendously over this period.

The economics literature using standard regression analysis to account for household and macroeconomic conditions has generally found that medical debts are not the most important cause of bankruptcy filings. Other factors, such as the financial benefit from a bankruptcy filing or other types of debt, such as large credit card debts, are more important predictors of bankruptcy filings.

Having said that, however, I do not wish to underestimate the serious effects of medical problems on particular families. Rising healthcare costs are clearly an area of growing concern, and there is an urgent need to tackle the issue. At the same time, we should recognize that families are being pushed to the brink of bankruptcy for a multitude of reasons. While some recent reports, based on thinner evidence and less robust methods, would have us believe that rising healthcare costs are in fact the main factor responsible for household bankruptcies, I hope my testimony has provided a more substantial basis for concluding that this is not the case.

I would like to end by stating that in order to find a solution we first need a correct understanding of the problem. The most effective solution to the problem of rising bankruptcies in these tough economic times is to help families keep their jobs, retain their earning power, stay in their homes, and live within their means. If economic problems nevertheless become unmanageable, the bankruptcy system is designed precisely to give families a fresh start by discharging some of their debt. If we mistakenly focus too narrowly and simply on medical indebtedness, believing it to be a bigger problem than it is, we will be even further away from the solution we need.

Mr. COHEN. Thank you, Dr. Mathur.

Our final witness is John Pottow. Professor Pottow is an internationally recognized expert in the field of bankruptcy and commercial law and a professor at the University of Michigan Law School, a school no longer known for football.

His scholarship concentrates on the issues involved in the regulation of cross-border insolvencies, and he has published in prominent legal journals in the United States and Canada.

Professor Pottow joined the Michigan law faculty in 2003. Prior to coming there, he worked at several law firms doing predominantly bankruptcy work. His practice focused on debtor representation and Chapter 11 restructuring.

He is licensed as a barrister and solicitor in Ontario, and he—but he is an attorney in Massachusetts.

Thank you, Professor Pottow. Will you proceed with your testimony?

**TESTIMONY OF JOHN A. E. POTTOW, PROFESSOR OF LAW,
UNIVERSITY OF MICHIGAN LAW SCHOOL**

Mr. POTTOW. And thank you. It is my pleasure. Thank you, Mr. Chairman, distinguished Members and honored guests. This is really an honor and a pleasure to participate in this hearing.

What I thought I might do is quickly speak about some of the academic studies you are going to be hearing about when you work through these difficult health care issues to see if I can provide some guidance at cutting through the morass of numbers.

And then if I have time, which is unlikely, I would like to share some of my own data on the rising problem of elderly Americans, elder Americans, who are filing for bankruptcy at an alarmingly increasing rate.

The first thing I would like to do is talk about some of the methodological issues of bankruptcy filing and medical bankruptcies.

And I think the single most important thing I would like Members of this Committee to think about is that an academic study that distinguishes between something called a “medical debt” and a “medical bankruptcy” and then takes something like a credit card and calls that an “other bankruptcy” is entirely missing the point.

There is no artificial distinction in the real world—and I can say this from academic research; I can say this from doing consumer pro bono cases which I still keep my license for—there is no distinction between a medical debt and a credit card debt. You are allowed to charge co-payments and hospital bills on your credit card.

So if you base an academic study on looking at court records, and you read the list of the creditors, and it says St. Jude’s Hospital, you say, “Oh, that is a medical debtor, okay,” then it says Visa, “Well, that is not a medical debt, no, that is credit card,” that is just wrong. And you are getting limited nuance on the insight.

So I urge very strong caution at trying to gauge the amount of medical bankruptcy by studies that cannot look at the actual identity of those debts and simply use crude categorizations of credit cards.

Secondly, and relatedly, I think that there is a mis-emphasis in some studies on the idea of medical debts alone as the only way of gauging what a medical bankruptcy is.

And this just may be reflective of academic disciplines of economists versus law, but what legal scholars are interested in looking at is are people going bankrupt through no fault of their own, because there was much discussion in the bankruptcy debates about whether people were shifty gamesmen trying to game the bank-

ruptcy system, or they were just playing by the rules and went bankrupt through no fault of their own.

And so from that perspective, we don't really care whether someone went bankrupt because they had a heart attack and then had to reduce their work hours or had a heart attack and then had very expensive bills to pay for that heart attack. Both of those people went bankrupt for reasons for which they should not be blamed and should receive protection.

Now, even if I were to grant the distinction and say, "Well, the first guy who went bankrupt because of a heart attack—that is just his tough luck and his bad health, but that is not a problem with the health care system, that is just a problem with his healthiness level," I am not even sure I would grant that concession.

I am not sure that makes logical sense to me, because the reason one might have a medically caused bankruptcy like a heart attack could simply be because you haven't had your blood pressure checked for 10 years or 20 years, and you never went to see a doctor, because you had insufficient medical insurance in the first place.

Had you had proper health insurance, you might have had preventative medical care that could have prevented that medically caused bankruptcy in the first place.

So again, I caution against these artificial distinctions that I think really miss the forest for the trees.

The next thing I want to talk about briefly is what I call an epistemological conundrum of people really fighting over is it 29 percent, or is it 39 percent, or is it 60 percent. I think it is important. I think it is important at an academic level, but at the broader level of congressional policy, I—my testimony is it is too high, whatever you use as the most conservative metric.

If you even take the most—you know, the conservative, conservative—just people who said on questionnaires, "Why did you go bankrupt," "Health reason," you are still looking at numbers that are over 30 percent. And that is a lower bound which is simply too high.

Now, in my own data, which I have just run; I haven't error checked yet—lawyer's caveat—if I look at just elder Americans, people who are over 65, and I use Dr. Woolhandler's thresholds of defining medical bankruptcy—so I don't want to get into the fight of whether that is the right one; I want you to be able to compare apples to apples—we are seeing people—on my questionnaire, 46 percent of elderly bankruptcy filers said they filed bankruptcy for medical reasons.

Thirty-two percent said they filed bankruptcy because they had medical bills. Someone selecting either of those two choices—they either ticked "my medical bills are too high" or "I had a medical problem"—that is 49 percent of elderly bankruptcy filers.

That is particularly disturbing for two reasons. Number one, the elder Americans are the fastest-growing rate of bankruptcy filers. In 1991, they were 2 percent. In 2001, they were 7 percent. In 2007 they are now—sorry, now 7 percent. If I take that as 55 and older, in 2007 they are 22 percent. So concern number one—they are the fastest-growing group.

Concern number two, we are supposed to have Medicare. Right? If you are over 65, you should have—I mean, there are some people who don't qualify, but the lion's share of people over 65 in this country are supposed to have a government-funded health insurance program.

Last thing I want to say is please be careful of academic studies. I am not faulting you, sir, for throwing that Fraser Institute study, but that has already been discredited. You can go to a blog called "Credit Slips" and read the post by Professor Lawless.

But that Fraser Institute said, "Look, the bankruptcy filing rate in Canada is higher. Look at these 2 years, 2006 and 2007." And then they said, "Yeah, but why are you looking at those 2 years? Why don't you look at all the years?"

And then you take out the telescope and you look at 2001, 2002, 2003—and by the way, 2008, after 2007, and guess what? Every other year the filing rate is lower.

And so you ask the authors, "Well, why did you pick those 2 years to say that the filing rate is higher in Canada and just those 2 years? Was there something special? Was there a new bill that was passed in Canada?" And you don't get a very satisfying answer.

So please be careful with your reliance on academic studies.

[The prepared statement of Mr. Pottow follows:]

PREPARED STATEMENT OF JOHN A. E. POTTOW

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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 Project¹

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

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

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

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

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

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

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

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

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. Himmelstein, Deborah Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MEDICINE 741 (2009), at text accompanying note 13.

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

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

Elder Americans in Crisis

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

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

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

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

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

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

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

- Incurred more than \$5,000 or 10% of annual household income in out-of-pocket medical bills (30.2%). (25% for just the \$5,000 uncovered medical bills part.)
- Total, one or more of the above criteria: 67.3%.

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

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

Bankruptcy Law

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

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

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

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

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

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

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

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

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

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

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

Proposals

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

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

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

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/LawProfslLetter.pdf> (imploping Congress to consider predicted costs and inefficacies of the means test and BAPCPA).

¹⁷ See Medical Bankruptcy Fairness Act, H.R. 901, 111th Cong., (2009), § 2 (defining “medically distressed debtor”).

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

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

If you'll indulge me, I would like to close with a quick personal anecdote. About twenty years ago when I first came to the United State as a college student from Canada, where we have universal healthcare, I was hit by a car biking to class. I was taken to hospital in an ambulance to be treated for a separated shoulder (the bike was crushed beyond repair and became urban art in our dormitory). As I was lying on the stretcher in a neck brace in the triage room, the first question I was asked – the 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.

Mr. COHEN. Thank you, Professor Pottow. I appreciate your statement.

And now we will start the questioning, and I will recognize myself for 5 minutes.

Mrs. Edwards, you talked about repeat filings. Would you talk to us about your thoughts there and changing the bankruptcy code when there is an identification of a person that had a bankruptcy for medical causes?

Mrs. EDWARDS. It is very often the case that a debtor filing for medical reasons may file actually too early.

If they are not charging their medical bills on their Visa card, if they are simply dealing with the medical collection agency, medical providers are not in the business of collecting debts, and you will—the practice is—you know, is it 32 days old? It goes to a collector.

And the collector is in the business of trying to collect what they can, moving to judgment, and basically forcing the debtor into bankruptcy.

Other kinds of creditors—Visa, for example—they are happy to add on the additional charges every month. You make the minimum payment and part of their business actually discourage people from paying off entirely because they want to get the high interest rates on the recurring debt.

So medical debtors are very often forced into bankruptcy early. They are forced in, and forced in while they still have chronic conditions. And since a large number of people who have excessive bills are the people with chronic conditions.

I know my particular condition, metastatic breast cancer—extremely expensive to deal with, and though I have coverage, insurance coverage, that seems to be covering it, I certainly sit in rooms with people who do not.

They file bankruptcy and then they have to wait—depending on the kind of bankruptcy they have filed or what chapter they filed under, and other criteria, they have to wait 5 years or 8 years.

What if they have one of those medical providers who says, “I am not going to give you continuing care until you pay off this previous bill?” They may be in a condition where they are simply not going to get care if they are not permitted to utilize the bankruptcy system.

I don’t think you want them—you know, you don’t want repeat filers—we want to discourage repeat filers. We want to address the underlying problem.

But where you have this situation, you may want people, if they meet certain criteria, at—a particularly high percentage of their debt that is medically related—you may want them—in order to encourage their continued health and also to encourage their continued productivity, you may want to allow them to file more frequently than permitted.

You would want stringent requirements to make certain that that is the category they fall in, but you may want to reduce that period of time.

Mr. COHEN. Thank you. Thank you, Mrs. Edwards.

And, Professor Pottow, are there other situations, maybe like with the counseling, that might be unique to medical bankruptcies?

Mr. POTTOW. Yes. I think so. I know there is some legislation proposed—I think it is H.R. 901—that says, “Why don’t we try to carve out a definition of medically bankrupt and see if we can reduce some of the more onerous bankruptcy law provisions for these medically bankrupt?”

It seems one area that would be—for example, the means test is one example. Other areas that the new bankruptcy—I guess it is not new anymore—that the current bankruptcy bill requires is compulsory pre-bankruptcy credit counseling and then in-bank-

ruptcy financial education or financial rehabilitation courses, and those are compulsory. No one gets out of those.

And so one can question if you are assuming you are able to come up with a good definition of medical bankruptcy and it is workable—if you have someone who has got—“I went bankrupt because I had metastatic breast cancer and I didn’t have generous health insurance,” I don’t know what use it is making them sit through—it is like traffic school—you know, sitting through, like, compulsory—“Well, you know, here is your education. Don’t get breast cancer next time.” It just seems to me like a waste of time for everyone.

So there could be little ways of tinkering on the edges—not as grand as redesigning the health care system, but just little things with the bankruptcy code that might help.

Mr. COHEN. Thank you. I think we might get bipartisan support for that. That is good. Thank you.

Dr. Woolhandler, Dr.—and is it Mathur? Thank you—basically said that her study and your study come to different conclusions and in essence doesn’t believe that bankruptcy filings have probably been caused by medical debt, and it is a small matter. She cites the Executive Office—the U.S. Trustee study from 2000 to 2002.

Would you comment on Dr. Mathur’s belief that medical debts are not—are not a major cause or concern for us here?

Dr. WOOLHANDLER. Well, we could spend a lot of time dissecting these different studies. I am actually—I train researchers in the medical school at Harvard, and I spend most of my days sitting in seminars and going through research technique and telling you why different research projects yield different conclusions.

What I can say is that this paper was peer-reviewed at the American Journal of Medicine. Of the 3,000 medical journals in the world, this is ranked either number 11th or number ninth in terms of overall impact. It was reviewed by other scientists. It has gone under very rigorous critique and review.

The thing that really differs in our study from other studies is we ask the debtors what happened. And we didn’t just ask them one question. We asked them dozens, even hundreds, of questions to get a full picture of what happened.

And what we found is that many people said they were bankrupted because of medical debt. Others said, “I was—I filed for bankruptcy to pay a mortgage.” “Well, why did you take on the mortgage?” “To pay my medical debt.” Other people said “Too many collection calls.” “Well, you know, why did you have so many bills?” “Because I missed work because I was ill.”

“Too high a credit card balance.” You ask them, “Well, why is the credit card balance so high?” It turns out if you can’t pay for drugs at a drugstore, your only option is to put it on your credit card. Your only option is to put it on your credit card, because drugstores don’t offer credit.

So 19 percent of people in our study said their highest medical cost was actually the pharmaceuticals. So the only way to get this kind of data is to ask people why they filed for bankruptcy, and ask them in enough detail to figure out what really happened.

And you know, that is what we did, and that is the studies we have done. They passed peer review. There are other studies looking at other data, but they can't actually get at this question of the real reason behind the bankruptcy.

Mr. COHEN. Thank you. I would like to give Dr. Mathur an opportunity to respond.

In your statement, you said that the Survey of Consumer Finances showed medical indebtedness has not changed significantly.

Apparently, I believe both Dr. Woolhandler and Professor Pottow feel that that is not necessarily the case, and that this—that the Survey of Consumer Finances didn't go into what the response was, and that medical debt was not distinguished from goods and services.

Did you go beyond what they said in that survey to see if there were credit card and/or mortgages caused by medical debt to go beyond the initial response?

Ms. MATHUR. So the Survey of Consumer Finances is actually—it samples like 4,500 families. It tracks them. It has been tracking them, I think, since 1968.

And basically, what they do is they ask every family what their financial situation is. They ask them their debt and asset levels. They ask them how much of it is medical debt, how much of it is credit card debt, how much of it is—you know, “Did you file for bankruptcy? When did you file for bankruptcy?”

And the—and that is the clearest picture that you can get of what is actually happening with the average American family over this entire period. And if you look at the average debt levels that the—that that survey shows, they haven't changed much since 1989, between 1989 to 2004, and even between 2004 to 2007.

The other survey that I mentioned, the Panel Study of Income Dynamics, actually asked exactly the question that you asked. It said, “Why do you think you filed for bankruptcy?” And instead of doing, you know—your survey was sort of limited because—don't report what the other reasons were. All of your reasons were entirely related to medical reasons.

That survey actually asked people, “Did you file”—you know, “What was the primary reason for filing? And you can rank the different reasons.” And if you actually look at the data, that survey shows that only 9 percent of people claim that medical debts were responsible for the bankruptcy filing.

So when you give them a choice between is it a medical debt reason or is it a credit card debt reason, I assume that people will make that distinction. And that survey clearly shows that the largest reason was non-medical debt, was credit card debt.

So I think there are numerous other surveys, you know, surveying a much larger sample of people asking, you know, more detailed questions than were asked in the study and that come up with a much lower number than you did.

Mr. COHEN. Yeah, I think that—the Chairman is asking me, in the spirit of *Saturday Night Live*, to give you an opportunity to respond, Doctor.

Dr. WOOLHANDLER. Sure. I guess we are going to go into the details of this. The Survey of Consumer Finance study has a problem

that is well stated by the author, Buck, where he says that the question was actually, "Did you take out any loans?"

So many people will not think of a—paying off a hospital bill over time as taking out a loan. So if you can't pay your hospital bill, they say, "You know, pay \$100 a month for the rest of your life." People won't list that as a loan.

The other thing is he had no data about credit cards. And yet we are hearing that a lot of people these days, when they can't pay medical care and they are panicked, the first thing they do is pull out a credit card.

So the Survey of Consumer Finance is not adequate to the task. Nor, frankly, is the PSID, which is a good study, but it had a grand total of 74 bankruptcies in the entire study. They identified half the rate of bankruptcies that would be expected in the population from which the sample was drawn—can't possibly be an adequate sample or an adequate representation of bankruptcies in this country.

Nonetheless, PSID does show some substantial rates of medical bankruptcy, unlike the Survey of Consumer Finance.

Mr. COHEN. Thank you.

And in the interest of time, we are going to move to questioning from our Ranking Member, Mr. Franks.

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

You know, Mr. Chairman, I guess it is important for me just to say something by way of overview. I recognize, I think, as everyone in this room does, that people encountering medical challenges and sudden disasters in their life affect them in every way, including financially.

I mean, I hesitate, but I will tell you that I had 11 surgeries before I was 9 years old due to some situations from birth defects. And it was a profound burden on my family. And so I understand that those things are real.

And I know that there are some disagreements here among the academics as to some of the causation of bankruptcy.

Professor Pottow, I would suggest to you that the overarching perspective of the Fraser study was that nationalized health care doesn't demonstrably reduce bankruptcy. And I think that is a—one that is—strong evidence here.

But I guess here is my big concern. And that is that somehow that the answer to medical bankruptcy is nationalized health care. The professor—Woolhandler said that private insurance is fundamentally defective. Now, those are her words, not mine.

She said that, you know, a single-payer system would save hundreds of millions of dollars—again, her own words and not mine. And I would just suggest two things. First of all, if it saves hundreds of millions of—it will be a first in history where government doing something of this complexity actually saved money.

And if, indeed, private insurance is fundamentally defective, it leaves only the government option. And here is my concern. With all of the crises that people face with health care, if you put it in government's hands, even to a partial extent, you will do a couple of things.

You will diminish the dignity of the patients. The pressure will be on giving less health care—that would be the only outlet of the

system, because there is tremendous pressure in the system no matter what we do.

And I am convinced that health care will become more expensive, and the ultimate result will be those people in crises, like my family was, will simply not be able to navigate the bureaucracy, and instead of having financial bankruptcy, we will have health bankruptcy.

And I am very, very concerned about that, because, you know, the highway of history is littered with the wreckage of governments who thought that the socialistic perspective or tendency would somehow create more productivity and create products or services that would be better and cheaper.

The only thing that has really proven in our history to do that is a private market that instigated responsible activity on the part of everyday people. And I believe that this country has tremendous capability.

And I want to mention one other example here. There was a time when government was a kind of quasi—because, you know, I know that my friends on—I should say my left, but I can't—my friends on the other side of the aisle believe that I am mischaracterizing a nationalized or government takeover of health care. And I understand that.

But let's then, for the sake of argument, or I hope the sake of enlightenment, look at what happened when government had a quasi-involvement in the telephone company. There was a private—Ma Bell was a private company but government was all in the middle of it and controlled it and regulated it.

And again, telephone service was enormously expensive. And we had almost no—and if we want to do that to health care, that is exactly the wrong direction.

But what happened when we encouraged the private sector to be really involved? All of a sudden there was an explosion in technology that made telephone services and all kinds of the related services much cheaper and much better for everyone.

And my concern is that we are going, again, in exactly the wrong direction with the idea of moving in a government direction of health care.

If we want to help those who are—and this is important—those who are under-insured, that can't be—find insurance because they can't afford it, why doesn't the majority offer something where we would give them a draft to go out and buy the private health care insurance of their own choice?

That is empowering those who don't have what they need. That would change the entire dynamic, and it would incent a private competitive market system which would help everyone.

Let me ask a question right quick before I am out of time.

Dr. Mathur, the recent Harvard study that you have talked about today—I want to give you a chance—concluded that medical debt significantly contributed to 62 percent of consumer bankruptcies.

I want to give you another chance. Do you believe the study accurately reflects the impact of medical debts on consumer bankruptcies in America?

And are you aware of other studies that represent this high of—similar results?

And what accounts, in your judgment, for the high correlation of medical debt and bankruptcy that is found in the Harvard study?

Ms. MATHUR. I think the number is definitely overstated. I think the survey response of the—you know, even if you take the respondents and their own—when they asked them the question of what actually caused the bankruptcy, that number in their own survey, by their own estimates, is 29 percent.

Whether the survey is a random sample, whether it, you know, would sort of pass—I think sampling 1,000 people, you know, and asking them only questions related to whether there were any medical reasons for the bankruptcy filing, whether, you know, you had any bills, whether you, you know, lost sort of weeks of work a year prior to the filing, I think that is, you know, sort of overstating the case.

I think at the most, what you can take from the study is that maybe 29 percent of the respondents believe that medical bills had something to do with their bankruptcy filing. Whether it was the actual cause, whether it was the—you know, the proximate cause, whether it was the immediate cause of the filing is also not certain in the survey that they did.

I have now, you know, surveyed the entire economics literature. There are now—there are no other surveys, you know, again, peer reviewed, published in the Journal of Finance and other places, that would suggest that, you know, that number is even close to being accurate.

I think it is an—statement. Every study that I have come across actually finds a much higher role for credit card debt where you can distinguish between the two, where, you know, any academic study will—you know, would not pass muster if it simply said, “Oh, we are including credit card debt but we are not sure whether medical debt is a part of it.”

So to the extent that, you know, you rely on the peer review process, no study has actually concluded that medical debts are the single most factor—you know, most important factor causing bankruptcies today. Thank you.

Mr. COHEN. Thank you, Mr. Franks.

And now we would like to recognize for 5 minutes the Chairman of the full Committee, Mr. Conyers, of Michigan.

Mr. CONYERS. I am setting aside my questions because Trent Franks and I and Steve King and Howard Coble and Jim Jordan—we are working this thing out.

Dr. Mathur, we maybe will or will not see you again, but we take your statements at their face value, that they are intended to convey a point of view.

And so let me ask Dr. Woolhandler and Professor Pottow and Elizabeth Edwards—let’s just go through this again. Sometimes it may be repetitive, but we want to try to straighten this out.

Steffie, what do you say?

Dr. WOOLHANDLER [continuing]. Asking specifically about the numbers of people in—

Mr. CONYERS. Well, the—

Dr. WOOLHANDLER [continuing]. In medical bankruptcy?

Mr. CONYERS [continuing]. The discussion—see, here is what I do. Here is the only way I improve in this system we are in. We are going to take your statement and we are going to go through it sentence by sentence for accuracy. That is the only way we get better.

But what are your impressions? What are you up here today—want to add to this review?

Dr. WOOLHANDLER. Okay. Well, I think the question of whether national health insurance would actually save money is an empirical question that you can answer by looking at places that have tried national health insurance, which is not socialized medicine. It is socialized insurance, like Medicare for all.

But you can look and say, “Where they have national health insurance, does it cost more or less,” and the reality is the United States is paying twice as much as the average for other industrialized nations. We are the only industrialized nation that does not use nonprofit national health insurance.

So the scientific empirical answer about what is the most affordable, if we accept international evidence, is going to be that national health insurance is more affordable. The reason for that is the tremendous administrative savings that you get with national health insurance.

So when you have one payer like a Medicare-for-all type program, not only do you get the administrative savings at the insurance center, but it also means doctors and hospitals don’t have to have their complex billing apparatus, their complex staff of clerks who argue with the insurance company, doctors like me don’t have to spend my time on documentation that is just there to argue about who gets paid.

And Canada has administrative overhead in their system of only about 16.7 percent. In the U.S., it is about 31 percent of total health spending. And again, that is a peer-reviewed study—we have been talking a lot about peer review—New England Journal of Medicine, 2003.

So if we were able to reduce our administrative costs to Canadian levels, we would save about \$400 billion a year, which is the money we need to cover all of the 47 million uninsured, with money left over to plug the gap in coverage that people now have, to eliminate co-payments, deductibles and uncovered services.

And in fact, in Canada, there are not co-payments and deductibles. There is not lifetime limits. There is not rescission, albeit rescission is a small problem in the United States, affecting a tiny fraction of people, and actually was not an issue in our study. Most people did not experience that.

But they don’t have any of that in Canada because they have Medicare for all, everybody in, nobody out. So we can grandstand and—and talk about what might be—try to project the future. We don’t have to do that. We can really look at the evidence and see what has happened in countries with national health insurance.

Mr. CONYERS. Thank you.

Professor Pottow, what—

Mr. POTTOW. I would like to respond quickly, if I could. First, I would like to briefly wade in again on these methodological ques-

tions. And I feel somehow Dr. Woolhandler has been put in this almost defensive posture, and I think that is wrong.

In fact, if anything, I think her study is one of the most rigorous methodologically. And again, I cannot emphasize enough that when you talk to people who are filing for bankruptcy, first and foremost on their mind is not the accurate classification of their debts for academic studies of people who are questioning them.

And so they do answer things like, "Why did you go bankrupt," "Because of the mortgage," and it is only if you do that second level of in-depth survey analysis to say, "Why did you put a mortgage on your house," they say, "Because of the wife's surgery."

And so I don't see anything incongruous about that, the Woolhandler, *et al.*, study having higher estimates, because I think as you get through more gradations of understanding you are going to see those numbers go up.

Secondly, if I may just speak anecdotally as someone raised in the Canadian system, I mean, I don't know how much of this—and how much changed since I have been down in the States, but like I certainly didn't feel any lack of dignity and I think was raised pretty healthily.

The one thing that I was struck by coming to the American system was that you didn't have to get a referral. Everything—I think they try to channel much more through the primary care medical system in Canada, so if you want to go see like an orthopedic surgeon, you have got to wait till your primary care doctor does a referral.

And that may be like anathema to the libertarian culture of free medical choice here, or it might be a way of reducing cost, to have some doctor gatekeep that. But I don't have strong feelings—

The final thing I want to say was I really do want to get to the point that—I believe it was the—that Mr. Chairman who brought up about losing life's lottery.

From a bankruptcy perspective, I—if you lose life's lottery and you are now bankrupt, that is just like a terrible situation to be in, sort of like you have got two strikes at the same time.

And I am not making a claim of causation. I am simply looking at bankruptcy as like doing like post-mortem in the entrails of the people who are in the worst financial circumstances in this country. And if you find yourself there because you have lost life's lottery, that should be, to the extent we can design legislation, as minimally painful a respite as possible.

You should go in and out quickly. And if we can differentiate you from sort of charge card junkies, then we should try to do that with bankruptcy legislation. I am sorry I am not speaking to grander health care redesigns, but it is something I know a little bit more about.

Mr. CONYERS. Mr. Chairman, could I get enough time to let Attorney Edwards make any comments she chooses?

Mr. COHEN. Granted.

Mrs. EDWARDS. If I can sort of take this out of the context that we are arguing about medical bankruptcies, the problem with the extensive medical costs that people are suffering doesn't just reflect itself in medical bankruptcy.

It also reflects itself in a different area as well. It reflects itself in the number of foreclosures we have.

Christopher Robertson has done a study published in Health Matrix magazine—indicates 50 percent of foreclosures have as one of the causes one of the substantial—significant causes medical costs, both medical costs because they have lost their job—I mean, they have had to quit their job in order to take care of somebody who needed long-term care, and that wasn't covered by any insurance, and they needed—that was the cheaper thing for them to do. Or whatever the—but all related to medical costs and the inability of that family to meet its medical expenses.

You think of the larger economic problems we are having right now—you know, if the truth is we never had subprime mortgages, maybe half the houses on your street wouldn't be for sale because of foreclosures, because of subprime mortgages.

But half would still be being foreclosed because of mortgages that had to do with health care costs. And that continues to be an enormous problem.

When you think about the consequences of that, the consequences of that are the collapse of the real estate market, which means that our creditors, our banks, become under-collateralized, and that is part of the problem that has caused the—has the ripple effect.

Is it the only reason? It is not the only reason. But to ignore the fact that medical costs are part of the underlying problem with the financial meltdown that we have experienced would be to completely turn a blind eye to a significant problem that we can solve.

It is not just this is a problem out there that seems insolvable. We can solve this problem. I believe that Congressman Franks is probably being hyperbolic and didn't actually mean that the Federal Government should be making a contribution to pay for the 47 million people who are uninsured, and I suppose an additional for people who are under-insured, the 25 million who are under-insured.

But we are talking about—you know, the enormous amounts of money you end up talking about—we are talking about \$6 trillion over 10 years—is what we would be talking about in order to—in order for—that is the reason we are not talking about it. We are not talking about doing that. It is entirely too much money.

We have to solve the problem in a way not only that deals with the problem of medical expenses and the moral and financial need for medical care, because it has so many repercussions, not just in the financial market but in businesses.

It creates \$2 billion—uninsured loss of productivity—\$2 billion a year. I mean, this is a substantial amount of money. And we can address all of those issues, but we have to do it in a way that makes economic sense.

This suggestion simply, you know, for whatever theatrical reason it was presented—it is simply not the kind of solution we need to be looking for.

Mr. COHEN. Thank you, Mr. Conyers.

I now recognize the gentleman from Ohio.

Mr. JORDAN. Thank you, Mr. Chairman.

Mr. COHEN. And would you let us know why you got that nice note?

Mr. JORDAN. I believe it was the Chairman saw the Ranking Member this morning heading over to an event. The Ranking Member was headed to an event I was having, and they happened to exchange greetings, and Mr. Smith said he was coming to my event, and Mr. Conyers was kind enough to say something nice about me.

So I appreciate that, the gentleman from Michigan and the Chairman.

In your research have you all seen that when a family or a patient is experiencing difficulty paying their medical bills, debt—has it been your experience that hospitals and physicians are willing to do what they can to work with that family, to see if there is a way they can pay it off over time?

What has your research shown in that area, trying to help families avoid what we are—you know, the bankruptcy we are talking about here today? And I counsel—you can start wherever. We will start with the physicians.

Dr. WOOLHANDLER. Yeah. Well, actually, at the end of the surveys in 2002 and 2007 we asked people to give a narrative report of what happened, like a longer story. And I actually read all of the reports from the 2001 study.

And the fairly typical study would be like a—I mean, this is a real person, a schoolteacher, who gets a heart attack, can't teach school, loses her health insurance, gets a \$20,000 hospital bill.

A savvy consumer goes to the hospital and negotiates and gets the hospital to write off the entire bill. But then she is bankrupted anyway because of the doctors' bills and the bills for medication she has put on her credit card, okay?

So savvy consumers go and try to negotiate these things, and occasionally they do get a deal, but that doesn't save people from bankruptcy because they can't get a deal that covers all of their bills. They can't cover the hospital bills and the doctors' bills and the drug bills all at the same time.

Mr. JORDAN. Dr. Mathur, that the—

Ms. MATHUR. I don't think I can speak to that.

Mr. JORDAN. Okay. Okay.

Ms. MATHUR. I don't have—

Mr. JORDAN. That is okay.

Mr. POTTOW. There is some anecdotal stuff about hospital collection procedures. There was a case out in Connecticut where they were attaching liens, but that is not a systematic academic study.

One thing we do have from the sociological, psychological literature that I have seen is that respondents who are trying to juggle financial stuff always want to pay their health care provider first, and I think that maybe speaks to what Mrs. Edwards was saying about having to go into that doctor's office.

And that, quite frankly, may be one of the reasons why you see the incidence of credit card debt rising, because it is a little bit more anonymous to put it on the credit cards than—so that is another piece of academic data I have.

As for hospitals themselves, I know that there is an emerging product of like a health credit card, where you put—it is supposed

to put structured payments on an amortized payment schedule, but you can actually use it as a general purpose charge card. But again, I am not familiar with the academic studies.

I will say my general research with credit cards makes me extremely nervous about that sort of product, if you are getting into that, but that is a—that is a separate hearing, I believe.

Mr. JORDAN. And you mentioned that people are more inclined to deal with the health debt first, and why is that, just the relationship they have with their physician, the trust they have there? Is that part of it?

Mr. PORTOW. I think that is right. I think the worry is that you would go up to your doctor's office, and if you haven't paid your bill last month, then you kind of get—it is awkward talking to the nurse, and you—maybe you are not going to get the full level of trust.

I think perhaps Mrs. Edwards would be able to speak—

Mrs. EDWARDS. The truth is if you are having a problem with Sears, you can, you know, get your washer-dryer someplace else. If you are having a problem with your doctor—you know, you have a continuing relationship, and you need that continuing relationship because health care is so important.

One of the things that we are—that you see sometimes is if you have an insurance policy, you will get one kind of bill. You might get a larger bill if you are uninsured.

And part of the reason for the larger bill is that we have a lot of charities that try to help out people who don't have—who can't work things out, or they—but they can only pay 20 percent of the bill.

So 20 percent represents a—closer to the insurance number, so that is why you see an inflated—you often see an inflated number for the health care provider, usually a hospital as opposed to a doctor—an inflated number for that.

So that skews a little bit of what you are talking about.

Mr. JORDAN. Let me change, because I want to go to something that happened last week and just get your thoughts, since we are talking—we have sort of talked about health care in general.

Last week, the President of the United States made a statement during his press conference that I found troubling, and I would like to get your thoughts. And again, we will start with the physician in the witness panel.

But if you remember during that press event, he made the statement that doctors will, in some cases, take the tonsils out of a child not because it is in the best care of that child, that patient, but because they will make more money.

And I found, frankly, that statement incredible, that—I mean, you go—I said this in a speech yesterday back home. You go pick a random sample of 100 people, 1,000 people—pick any number you want—of Americans and ask them the simple question, "Who do you trust more, a politician or a doctor," and my guess is 100 percent of them will say the doctor.

And yet the President of the United States, in the midst of this health care debate, made that kind of statement. And so I would like your thoughts on the President's comments last week to the American people. We will start with the doctor.

Dr. WOOLHANDLER. Well, there is a tremendous amount of over-treatment in the United States. There is a tremendous amount of overuse of expensive technologies, most of which is useless but some of which is actually harmful to patients.

Mr. JORDAN. Driven by what? Are you saying your colleagues, Doctor, are making decisions—financial interest? Many of us would argue that if we would maybe look at some reforms in the tort system, there may be less of what you just described.

Dr. WOOLHANDLER. Well, I think there is a bias toward intervention. It is there in the medical literature. It is there in the finances, so that the doctor and the hospital—

Mr. JORDAN. Remember, the President's statement was—the President's statement was not about—the President's statement was flat-out they do it for more money. They put the patient's care secondary to more money, an attack on physicians across this country.

I want to know what your thoughts are as a physician about that statement.

Dr. WOOLHANDLER. Okay. There are a few scoundrels in my profession who only do surgeries to make more money. But for the vast majority of them, it is not that they are scoundrels.

It is that the entire educational system, the entire payment system, is biasing us toward being overly invasive and overly intensive, so that all the new medical students, all the new residents, are being trained to order a C.T. scan every time someone has a bellyache or a cough.

That is tremendously expensive. It is invasive. It exposes patients to radiation they don't need. They are not being bad people.

They are just working in a system that biases us toward over-treatment, and we—in other countries, some of the other countries that spend less do it, you know, by having all these C.T. scans and tests, or whatever, but using them more sparingly.

And that is one of the things we would want to do with a single-payer system, is do better health planning to—

Mr. JORDAN. Okay. Okay.

Dr. WOOLHANDLER [continuing]. Shift away from excessive treatment and toward the patient—

Mr. JORDAN. Can I get a response from the others?

Dr. WOOLHANDLER [continuing]. And primary care.

Mr. JORDAN. And I won't ask any more. Can I get a response from the others, Mr. Chairman?

Mr. COHEN. Sure, Mr. Jordan.

Mr. JORDAN. All right. Thank you.

Let's go with Mrs. Edwards and the professor.

Mrs. EDWARDS. To follow up on this, there is an emphasis on coded treatment. We have all seen the—you know, as the doctor or the nurse fills out the form and checks particular codes on the—that will translate into reimbursable treatments that the insurance companies decided are reimbursable.

There are some treatments that are not reimbursable—the kind of continuing care, a lot of the preventive care that we would like to see, the—you know, basically they wave goodbye to you at the door of the cancer center, even though you would like to be able to follow up—

Mr. JORDAN. Maybe—my question was do you think it was helpful for the President to make that kind of allegation, that kind of—

Mrs. EDWARDS. I—

Mr. JORDAN [continuing]. In the midst of this debate, in the midst—

Mrs. EDWARDS. I think—

Mr. JORDAN [continuing]. Of a question of whether the government is going to end up actually getting between you and your doctor, do you think it was helpful for the President to make that kind of statement?

Mrs. EDWARDS. First of all, I do not think it is an accurate statement that any of the policies we are talking about put the government between a patient and the doctor.

I think that that right now we have the insurance company between the two, but I don't think that any of the policies would put the doctor there.

I do think that doctors are being encouraged not by their guts or by their wallet, but by their administrations to make certain that the treatments they give have some code that is reimbursable, so to the extent to which—and I don't know what was behind the example that was given.

But the extent to which, you know, choosing between an uncoded treatment and a coded treatment, I think there is probably administrative pressure that the doctor could respond to more accurately to provide the coded treatment, not the uncoded treatment.

Mr. JORDAN. The context of his comments—if I could, Mr. Chairman, the context of the President's comments were real simple. You are going to give the kid amoxicillin, or whatever, you know, to deal with the sore throat, or you are going to take his tonsils out.

That was the context of his statement. He said doctors are going to take the tonsils out, even though it may not be the right thing, even though it is not the right thing to do, because they make more money.

Mrs. EDWARDS. I—

Mr. JORDAN. That was the context of the statement.

Mrs. EDWARDS. And I would like—I—

Mr. JORDAN. And I am asking—

Mrs. EDWARDS.—I am hopeful what it means is reimbursable—

Mr. JORDAN [continuing]. People who are experts in health care—

Mrs. EDWARDS [continuing]. As opposed to non-reimbursable treatments. I hope that what it means is reimbursable as—to non-reimbursable treatments.

And yes, there is an emphasis on making certain that the treatments provided are reimbursable, which means that we need to expand that—expand the reimbursement to include a lot of preventative care.

Mr. JORDAN. I am reclaiming my time, so I can go to the last two witnesses—or—

Ms. MATHUR. I am not a physician, but I think it does a big disservice to the doctors in this country, you know, to make a statement like that.

Mr. JORDAN. Thank you.

Mr. POTTOW. I don't want to speculate whether the President is trying to declare war on doctors, or whatever, but it seems to me that if there is—if there is—and my wife is a physician, too, so I am speaking from anecdotal evidence here, too——

If there is a treatment and procedure bias, so if you say, "Listen, this is the way the compensation system works. If you spend an hour talking to a patient with counseling, you get paid this dollar amount from your—for insurance reimbursement. But if you do the procedure, you get paid this higher level," then I can understand the gravitations toward doing the procedure thing.

So maybe what the President is saying is the way the current payment structure is right now is that it is—not only is it easier for defensive—because that is the inculcation of risk aversity that we train our doctors in—it is like, "Oh, God, I better err on the side of caution in doing more stuff," but also hey, guess what? You get paid at a fatter compensation level to do it, so there is sort of a double incentive.

And whether that is like, you know, inculcating a culture of malevolence or not of physicians, I don't know, and I don't know if the President is going to go there with the doctors or not. But that is just my response.

Mr. COHEN. Thank you, Mr. Jordan.

Now I will recognize the representative from the Bay State, the Cape, the Island, knowledgeable——

Mr. DELAHUNT. That is enough.

Mr. COHEN. That is enough. [Laughter.]

You are on.

Mr. DELAHUNT. Thank you, Mr. Chairman.

I would like to get back to the statistics in terms of the cost of health care. And there has been a lot of discussion during the debate on health care, comparisons versus Canada or versus Germany, versus, you know, other democracies.

And I think it was you, Doctor, that said that the cost of health care in Canada is half of what it is in the United States. Am I correct in——

Dr. WOOLHANDLER. The cost of health care in Canada is about half of what it is in the state—my home state of Massachusetts. However, Massachusetts is——

Mr. DELAHUNT. I am very familiar.

Dr. WOOLHANDLER. Yeah, higher than——

Mr. DELAHUNT. The Bay State.

Dr. WOOLHANDLER. Yeah.

Mr. DELAHUNT. Yeah.

Dr. WOOLHANDLER. Yeah. Right, and we are about 15 to 30 percent higher in terms of cost than the rest of the country. So if we just want to talk nationally——

Mr. DELAHUNT. Yeah, nationally.

Dr. WOOLHANDLER [continuing]. We would say Canada is just over half the cost of health care nationally on a per capita basis.

Mr. DELAHUNT. I guess the question that I have is what are we getting for our dollar in medical terms. Let's pick out longevity. Are we living longer than the Canadians?

Dr. WOOLHANDLER. No, sir. Americans live two to 2½ years shorter life than Canadians.

Mr. DELAHUNT. Give me some more comparisons. How do we do compared to the Germans?

Dr. WOOLHANDLER. Okay. People in the United States have a slightly lower life expectancy than Germans. Okay?

Mr. DELAHUNT. I find that very disconcerting, since I am paying twice but I am not living longer.

Dr. WOOLHANDLER. Well, most of western Europe people live longer, so French people, Scandinavians, people in Holland—they have complete free access to health care. They pay less per capita for health care. And yes, they do, indeed, live longer.

Mr. DELAHUNT. Right. I mean, I think we tend to be particularly proud of the quality of our health care, and yet it doesn't seem to be distributed in a way that for the average American, as opposed to the more affluent American, helps as far as longevity is concerned. Is that an accurate statement?

Dr. WOOLHANDLER. Yes, sir, it is.

Mr. DELAHUNT. And yet we are paying so much and getting so little in comparison. I mean, I think that is important to talk about.

I mean, I have to agree with you, Professor Pottow, and I respect both of your versions in terms of the methodology, but can we agree—can the panel agree—and I guess I am looking to you, Dr. Mathur and Dr. Woolhandler—that however you define it, medical costs are at least a significant factor in terms of bankruptcy.

Is that a fair statement?

Dr. WOOLHANDLER. Well, I obviously think the—

Mr. DELAHUNT. You—

Dr. WOOLHANDLER [continuing]. Answer is yes based on data we collected from people filing for bankruptcy.

Mr. DELAHUNT. Right. But you know, I mean, there is no one on this panel, believe me, that is a statistician—oh, maybe there is one, but it—you know, I mean, we are not particularly erudite in terms of math and probabilities and what have you, and I am sure that academicians can disagree and have a good, fascinating debate that would bore most of us in terms of the methodology.

But is it a fair statement to say that you can't discount medical—the cost of medical care in this country as it relates to bankruptcy?

Ms. MATHUR. I think, as Dr. Woolhandler's study had stated, that let's say 10 to 15 percent of bankruptcies—

Mr. DELAHUNT. I am not asking for—I am just saying—if you could give me—and if you can—

Ms. MATHUR. I would say that they would account for 10 to 15 percent of bankruptcies, and it—and leave it up to the audience to judge whether it is significant.

Mr. DELAHUNT. Significant. Okay. That is fair enough.

Mrs. EDWARDS, do you have any—

Mrs. EDWARDS [continuing]. Whether we are getting what we pay for?

Mr. DELAHUNT. Yeah, are we getting what we paid for?

Mrs. EDWARDS. We are clearly not getting what we paid for. I mean, in addition to—we are now—we have been always talking

about 17—16 or 17 percent of GDP. We now may be talking about upward of 20 percent of GDP donated—that goes to health care.

We use it in a tremendously inefficient way. And one of the reasons we do so is that we don't have the kind of competition for—in—

Mr. DELAHUNT. I guess the reason that we don't give the check to the private insurance company is that we don't want to pay for their profit, is that—

Mrs. EDWARDS. Well, the—

Mr. DELAHUNT [continuing]. Really what it is about?

Mrs. EDWARDS. Under the law, insurance companies—insurance is not like another—any other product, really. You know, basically, I mentioned Sears before. If Sears sends you—sells you a washer and a dryer, they make more profit. The more product they give you, the more profit they make.

Insurance companies operate exactly the opposite way. The less product they give you for what you—the more profit they make.

They have a fiduciary obligation under the law—and I concede that they—that they comply with this—insurance companies have a fiduciary obligation to their stockholders to maximize their profit. They have no fiduciary obligation to their insureds. And that creates an enormous problem.

It means that they—that when you have WellPoint's experience in California, where they were fined a million dollars—they operate Anthem Blue Cross. It is the largest health insurance company in the country. They operate Anthem Blue Cross.

They were fined a million dollars for systematically denying coverage to pregnant women. And that is a system that we—that perhaps could be corrected in the way that Dr. Woolhandler is suggesting, but also—but can be corrected also by less dramatic changes that are really calculated to solve those kinds of abuses.

When we solve those kinds of abuses, perhaps we will get, in fact, the coverage that we deserve. The problem isn't that we don't have the best health care in the world. People come from around the world—we hear stories of it all the time—to get health care here.

The problem is that those clinic doors are closed—

Mr. DELAHUNT. But that is just it. They come—

Mrs. EDWARDS [continuing]. To many Americans.

Mr. DELAHUNT. They come from all over the world.

Mrs. EDWARDS. Right.

Mr. DELAHUNT. You know, in the Bay State, in my home city of Boston, Massachusetts, we get a lot of very wealthy people, and we welcome them, from the Middle East, from Russia, from Japan—

Mrs. EDWARDS. Right.

Mr. DELAHUNT [continuing]. From everywhere, to come to get the best. But there are many in the Bay State, up until recently, who can't access that health care.

Mrs. EDWARDS. Exactly the point.

Mr. DELAHUNT. That is the difference.

Mrs. EDWARDS. Exactly the point.

Mr. DELAHUNT. What are we doing for the average American when we are paying twice and we are not living as long? I am put-

ting it, obviously, in very simplistic terms. But to me, that is what it is about.

Mrs. EDWARDS. And the problem is exactly——

Mr. DELAHUNT. I am not here, to be honest with you, to help deliver quality health care to sheiks from the Middle East.

Mrs. EDWARDS. Right.

Mr. DELAHUNT. I want to do it for the folks from South Boston.

Mrs. EDWARDS. And the problem is exacerbated in rural areas, where your care is so dispersed.

We have the capacity to make these corrections, and what we are doing is we are considering substantial health reform, which I should say the country appreciates your doing.

Mr. COHEN. Thank you.

And thank you, Mr. Delahunt.

In fact, I kind of surveyed my district, and hardly anybody in my district knew what M.D. Anderson was.

Mrs. EDWARDS. Yeah.

Mr. COHEN. Mr. Coble, are you—the gentleman from North Carolina is recognized.

Mr. COBLE. Thank you, Mr. Chairman.

Dr. Woolhandler, we have a few scoundrels in our profession, too. But I think the good news is most of the people in your profession and most of the people in our profession are pretty good folks. I think that is the bottom line of the good news.

Good to have all of you with us.

Mrs. Edwards, I think we all agree that there are a number of challenges facing people around the country generally, and in yours and my North Carolina specifically.

While health care is one of them, there are many others which seem to be linked to one common thing, and that is the economy. You touched on it earlier regarding the mortgages.

When the climate is favorable, problems appear to be less complex. Well, the climate is not all that favorable now. And I have no doubt but that the economy has impacted these bankruptcies and has furthermore impacted health care.

I am thinking cumulatively now. Automobile payment late. Home mortgage payment late. Credit card payment late. Health care payment late. Do you concur with that, Mrs. Edwards?

Mrs. EDWARDS. I concur that the situation is getting worse, not better, which just encourages—means we have more need to address the problem.

But the study that was done out of Harvard that Dr. Woolhandler participated in, is one of the senior authors of, was a study that was done, I believe, in 2007. So that preceded the current crisis.

Now, you can imagine how much worse it is, and I have spoken with my former colleagues practicing bankruptcy law, both from—people who stand in front of the judge and the judges, and the situation is considerably worse.

At the time of the 2007 study, a bankruptcy that followed an illness happened every 90 seconds. I hate to think how often it is now.

Mr. COBLE. I thank you.

Dr. Mathur, how do we define and quantify what is referred to as medical bankruptcy, A? And is there any empirical data with which you are familiar on which you would depend to analyze whether it is creating a significant impact on bankruptcy filings generally?

Ms. MATHUR. I think the only way we can classify a bankruptcy as being—and the way it is widely—you know, the study is being cited—is that medical bills are causing the bankruptcy filings. I think the authors need to clarify that we are not just talking about medical bills but, you know, anything—any medical reason, and they say that, you know, that is part of the bankruptcy.

By their own estimates, about 29 percent of respondents say that their—that medical bills were—you know, were like another cause of the bankruptcy filing.

I think to improve the study you would need to, as you said, you know, account for—and which standard economics literature does—is to account for, you know, tens of other factors that could have influenced the filing.

So you account for, you know, what is happening to average incomes in the state, what is happening to the average unemployment rate in the state, what is happening to our own income level, you know, are you facing, you know, job loss or any other factor that may be not linked to the—to any medical reason, and then say that okay, this part of it is purely due to the medical bankruptcy.

I have tons of papers cited in my longer testimony and also some that I mentioned here, and a lot of those papers say that yes, medical debts, you know, could account for some fraction of bankruptcy filings, but we believe that the other reasons are much more predominant.

You know, if you can distinguish between credit card debt and you can distinguish between, you know, medical debt, or you can distinguish between card debt or, you know, mortgages, then accounting for all of these different factors that could affect the bankruptcy, all of these other factors are—you know, might actually be more significant in explaining the bankruptcy filing than medical debts per se.

Mr. COBLE. I thank you for that.

Dr. Pottow, will you concur that there should be some sufficient safeguard—you mentioned elderly in your testimony—safeguards to ensure that the elderly can afford health care? And what programs, government or otherwise, are essential to meet that goal?

Mr. POTTOW. I think that is a good question. I think that there—some states, I believe, have experimented with having different levels of seizure protection laws or different levels of tax rates for residential properties for elderly people.

So those certain fixed expenses that they are going to be stuck with—like if you live in your home, and when the property taxes start going up, you may have a differential tax rate for an elder primary residence owner. Some people put different homestead exemptions by state.

In terms of the bankruptcy laws, maybe you could consider something like H.R. 901 for someone over 65, that—

I would like to respond, before I forget, sir, about the data that we have from the consumer bankruptcy project from this 2007 data

of seeing people filing for bankruptcy for all bankruptcies, not just the medical ones.

And one of the things that we did see when—in answering our questions and looking at their struggling with their bills is that we are seeing a trend where people are waiting longer to file for bankruptcy, so people are stretching themselves on their credit cards or with home equity loans a little bit longer before they fall off the cliff into bankruptcy.

What that leads me to believe is as we have a lagging unemployment effect with this economic recession is that you are going to see a—even larger uptick in the number of people who are filing for bankruptcy now, because they are still in the stretch period now as the jobs are going.

They will still flounder around and tread water with their credit cards, but eventually—I am crossing that, of course—but eventually, those chickens are going to come home to roost, and you are going to see even more financial distress of even more people filing.

Mr. COBLE. Thank you, Professor.

Mr. Chairman, you compiled a very fine panel of witnesses. I think it has been a very good hearing, and I yield back.

Mr. COHEN. Thank you, sir.

Mr. Scott, do you have—gentleman from Virginia—

Mr. SCOTT. Thank you—

Mr. COHEN [continuing]. Is recognized.

Mr. SCOTT.—Mr. Chairman.

Dr. Edwards, you alluded to the fact that we pay a higher percentage of GDP, higher amount per capita more as a Nation for health care and get very little of it. We have heard of life expectancy where we don't compare very favorably. Infant mortality is another indicator.

What are the other indicators that show that we are not getting—

Dr. WOOLHANDLER. Well, certainly, relative to Canada, we fail in almost every indicator. That is, when you look at deaths from cardiovascular disease, they are higher in the United States. Deaths from preventable and treatable cancers are higher in the United States.

When we did a review where we looked at people who were insured in both countries and compared the quality of treatment for people with insurance in the two countries, the outcomes were virtually identical.

If anything, death rates were a little bit lower, by about 5 percent, in Canada, just comparing apples to apples—that is, insured people getting health care in the two countries.

Canadians are healthier than Americans by almost all indicators, with a single exception, which is they are more likely to smoke. So there is a pretty substantial body of information saying that we are getting a very poor value for money in this country, very poor bang for your buck.

Other countries have—in addition to having universal health care, nonprofit national health insurance, and all other developed nations do, many of them have saved a lot of money by centering the health care system on the patients and on primary care, so that

you start with what the patient needs in their first contact with the primary care doctor. You strengthen primary care.

And then you call in these resources, the C.T. scans, the fancy surgeries, only when they are needed, and you pay for them in such a way that there is no reward for overuse.

Mr. SCOTT. Well, let me ask a blindly different question, because I think you are the only one that kind of alluded to a different between health insurance and health delivery systems.

In some systems, particularly a rural system, you are not going to have the critical mass for a high-tech operation, and I understand a couple of years ago, I think, the standard was if you didn't have at least 900 deliveries, you couldn't have a well-staffed obstetrical unit.

So the babies would probably be delivered by a family practitioner rather than an obstetrician. You would not have the neonatal pediatricians. You are not going to have the neural surgeons around if you don't have the critical mass.

Now, the fact that everybody—that is the system. Now, the fact that everybody has or doesn't have insurance doesn't change the system. You have got counties in Virginia that don't have any physicians, none, from time to time.

The fact that everybody has got a Blue Cross/Blue Shield card isn't going to create—it certainly isn't going to make it any less likely that there is going to be a doctor. It might even make it more likely.

And so can you say a little bit of the difference between the health delivery system and what we are trying to do in giving everybody access to the system we have?

And how it is a misrepresentation to suggest that if everybody has insurance, therefore you are going to have what is essentially in Canada a rural health delivery system, and therefore the quality would be worse? Would quality go up or down if everybody had insurance?

Dr. WOOLHANDLER. Yeah. Well, certainly, everybody—I believe everyone should have insurance, and my own experience in Massachusetts, where people tend to be very close to a doctor in Massachusetts—we are a small state—the problem is people have insurance but there is gaps in their coverage, like co-payments, deductibles, uncovered services, so they can't afford the care.

In a rural situation, it is obviously very different. Canada has a big rural situation. If you look at the map, you know, most of the Canadian population—90 percent of the Canadian population lives within 100 miles of the U.S., but they have huge, hundreds and hundreds and thousands of miles going north which are very sparsely populated.

And what they have done is developed a network of rural clinics staffed by these very gung-ho, smart nurse practitioners who can get on the telephone and get backup from doctors in the cities.

Not only that, but if a patient needs to be airlifted out, they get airlifted to the—to a tertiary center on the dime of the national health insurance.

So it is not a question of do you have insurance that will pay for you to be airlifted to Toronto. It is you need to go if that nurse practitioner there says you need to go. They airlift you out, so—

Mr. SCOTT. But the quality—

Dr. WOOLHANDLER [continuing]. They have come up with some novel solutions that—

Mr. SCOTT. The quality of care—

Dr. WOOLHANDLER [continuing]. Can address that.

Mr. SCOTT [continuing]. Is not diminished by virtue of the fact that everybody has an insurance card.

Dr. WOOLHANDLER. Oh, absolutely not. I think it increases the quality of care because then things are more likely to be distributed where they are needed. The services are there for people who need them and not where they are going to make more money because a person has a different type of insurance.

Mr. SCOTT. Thank you.

Can I ask one other question?

Dr. Mathur, you cited—in the studies you cited, would—do those studies count credit card debt and other credit caused by medical bills as a medical debt or as a credit card debt?

And also, if someone is in debt with a lot of credit cards because they paid for their hospital bill with cash but didn't have any money left over for groceries, gasoline, cash advance for the mortgage, would you—would those count as medical debt or mortgage, gasoline, grocery debt?

Ms. MATHUR. The study that I cited, the survey that I cited, basically gives respondents the choice of selecting the—between different types of debt that they have. And so you have to rely on the fact that people know best about what is actually driving them to bankruptcy.

Mr. SCOTT. So if someone is squeezed—

Ms. MATHUR. And so it doesn't matter whether—

Mr. SCOTT. So if somebody is squeezed financially because of financial debt—

Ms. MATHUR. If they think that—sir, my understanding is that if they believe that medical debts are the biggest—you know, even on their credit card, the medical debts are the biggest fraction of their debt, then I believe that they would respond to it as medical debts causing the bankruptcy rather than credit card debts. That is my—

Dr. WOOLHANDLER. I am familiar with most of the peer-reviewed literature. Things that have not been peer-reviewed, or that are not in the public domain, I really can't comment on.

But most of the peer-reviewed economics literature does not let you figure out if it is really a medical debt, for the reasons we have talked about. They don't actually know why you have got a credit card bill. They ask you about taking a loan, and people may not know they are supposed to say, "Oh, I pay off the hospital over time." It doesn't sound like a loan to most people.

The PSID, which Dr. Mathur did—a non-peer-reviewed study, but it is available on the Net, is in the public domain—used this data set with a grand total of 74 bankruptcies in it, half the expected number.

So the data that—you know, many of these studies are decent. A lot of them are old. But the data available from these public sources is not up to the task of figuring out what the root cause was.

You have to do the kind of study that we have done to really get at that.

Ms. MATHUR. I think the study that I am citing is the Domowitz and Sartain study, which was peer-reviewed and published in the *Journal of Finance*.

Dr. WOOLHANDLER. Yes, but that is an old study.

Mr. POTTOW. That is from 1980?

Dr. WOOLHANDLER. The number of medical bankruptcies were all—were lower in the past—is not particularly helpful, and that particular study, again, didn't ask people, "Why did you take the mortgage? What is going on with?"—

Ms. MATHUR. And that is precisely why you do regression analysis so that you can put in the—factors on the right-hand side and show what is causing it.

Dr. WOOLHANDLER. I teach regression analysis. It is part of what I teach at Harvard. It is not magic, okay? Regression analysis lets you look at multiple correlations at once, but it can't determine causality in some magic way that is not there in the data.

And if the data is not collected about why did you take that mortgage? What happened to you? Were you sick? If the data is not collected, there is no mathematical, statistical method in the world that will let you figure out causality.

Mrs. EDWARDS. One of the things that—this is such an excellent question that you have asked, because a debtor comes to your office, comes to the office of a bankruptcy attorney, and they—I need to file bankruptcy.

If they have paid off their doctor but their second mortgagor is on their case, and their credit card company is on their case, and you say, "Why do you need to file?" exactly the question that apparently was asked in this study, they are not going to mention the paid-off debts.

They are going to mention the second mortgagor who is on their case, and they are going to mention the credit card company, which is why it is so important to look behind those numbers and find—ask exactly the kinds of questions that were asked in this—in the Harvard study, whether or not you actually suffered a kind of illness, and whether or not you had these kinds of expenses over a certain number, because the debtor may not be in the very best position to analyze it in the way that is helpful to this Committee.

Mr. POTTOW. By the way, this is the best congressional hearing on multiple linear regression I have ever been to. [Laughter.]

Mr. COHEN. We are real good on that.

Mr. POTTOW. I did want to say the PSID actually—eventually just scrapped the idea of even asking bankruptcy questions. I think they only did it in that 1990—they brought it back in 2002.

And do they still do the primary/tertiary thing, or—

Ms. MATHUR. No.

Mr. POTTOW. Yeah, I think they gave up trying to graduate what is the first cause of your bankruptcy versus the second cause of bankruptcy, the third cause of bankruptcy, I think—realized in the research that it is just too hard to do it at that fine grain a level.

And the Domowitz study I think—if I am recalling it—maybe you can correct me—is from the 1990's and they analyzed medical fil-

ings from the 1980's, bankruptcy records from the 1980's? Or is it 1990's? Oh, sorry. Use the microphone.

And——

Ms. MATHUR. They used the 1999——

Mr. POTTOW. They published 1999——

Ms. MATHUR. They published in 1999.

Mr. POTTOW [continuing]. And they used—they used filings from what year?

Ms. MATHUR. From the entire—what they had up till then.

Mr. POTTOW. Oh, up through 1999, okay. So it is staling, but it is still okay. But it still uses——

Ms. MATHUR. Yes.

Mr. POTTOW [continuing]. The category—it still faces the categorization issue that Mr. Scott raised about medical or credit card, you have got to make your decision.

Mr. COHEN. All right. Have you all finished? Thank you.

Dr. WOOLHANDLER. Sorry about that.

Mr. COHEN. No, that kind of discussion we will let you all go. I appreciate Mr. Scott encouraging that.

Now—the gentleman from California, Mr. Issa, to be recognized——

Mr. ISSA. Thank you, Mr. Chairman.

You know, I will note that I get to watch Suze Orman's show, and one of her pet peeves is that people always say, when they take a look at their expenses, they start labeling how much they pay for their credit cards, and she has to say, "No, no, no, it is you are spending, not your debt."

And this is the challenge that—hopefully, this hearing brings up the question of are we asking the right questions in order to, if you will, do something about our growing tendency for bankruptcy.

But on that note, recognizing that the Chairman has cleverly found a way to get into the health care debate, which we have virtually no jurisdiction over, I am going to play into this just quickly and say any of you disagree that if we revise the bankruptcy statute so that we had, like we have in housing, limited recourse—you know, in almost every state, if you don't pay your mortgage, the only thing they get to take is your house.

You don't actually go into bankruptcy over your house in California, because you just walk away from your house. Now, if you pay your mortgage and run your credit bills up—credit card bills up, you could say that the mortgage was the reason, but assuming people are educated, in California there is no reason to go bankrupt over your house because you walk away from your house.

Any of you disagree that within the jurisdiction of this Committee we could solve this problem by limiting the recourse for medical debts?

Mrs. EDWARDS. I think that would continue to be—it would continue to be a problem, for this reason.

Mr. ISSA. No, no, I am not saying there may not be side effects into health care. I just want to understand, from the limited jurisdiction of this Committee——

Mrs. EDWARDS. People will still be inclined to pay their medical debts and incur obligations in other places which will force them into bankruptcy, because they have an incentive to pay off their

health care provider, with whom they—most of these people have continuing chronic conditions, which is why their bills are so high, and they need that relationship.

Because they need that relationship, they pay that bill over paying their power bill or paying their grocery——

Mr. ISSA. Okay. That is very true. I——

Mrs. EDWARDS [continuing]. Bill, so——

Mr. ISSA. I appreciate——

Mrs. EDWARDS [continuing]. It creates the same——

Mr. ISSA [continuing]. That, Mrs. Edwards.

Mrs. EDWARDS. The same result occurs.

Mr. ISSA. I appreciate that, but I would like to get to several questions in 5 minutes, so——

Mrs. EDWARDS. Yes, that is——

Mr. ISSA.—I will come back—I will come back to you, though, on it, I promise.

For the rest of you, do you agree on the basic bankruptcy question? We limit it, we can, in fact, reduce the cause, the prime cause, not the behavioral causes Mrs. Edwards talks about, but the prime cause?

So this Committee has that authority. Is that fair to say?

Mr. POTTOW. Since most of the—most medical debt is not secured the way mortgage debt is secured, so the issue with the California non-recourse anti-deficiency laws is that you can walk away and just leave the creditor to recover the secured portion of the debt.

The problem with medical stuff is most of those medical bills aren't secured, so there is no——

Mr. ISSA. They are unsecured, but they are, in fact, recourse. They can go after every asset——

Mr. POTTOW. Yes, so——

Mr. ISSA [continuing]. Thing is I can take your house if I am willing to, for a medical debt, but for a debt on your home, I can only take your home. And the same is true for—in many states with cars.

The reason I ask that is there is a two-step process. One, the bankruptcy law says it becomes non-recourse. The second one is if, instead of comprehensive health care——

Mr. POTTOW. Yes.

Mr. ISSA [continuing]. Reform and single-payer, we deal with, in fact, people who reach a point in which their chronic, ongoing or other health care requirements, in fact, are able to be taken to a court or any other ombudsman to say, "I can no longer afford my health care," for whatever reason, and the government in some capacity become the backup.

Now, we do this when you declare yourself indigent. We do this after your bankruptcy if you are unemployed. We do this for Social Security. Is there any reason this Committee should not consider the fact that we could do this in addition to any other consideration in health care?

And I realize some of you are here to talk about single-payer and comprehensive health care. Is there any reason that the government could not do that rather than only the single-payer solution?

Mrs. EDWARDS. A non-recourse, unsecured debt is no debt at all. If I lend you money and I have no recourse, I—basically, you don't

owe me. You have no obligation to pay me, which means I shouldn't lend you money, which means I shouldn't provide you services. And so a non-recourse, unsecured debt isn't a debt.

Mr. ISSA. Okay. Well, let's go through this for just a second. First of all, the European Union does reduce—and so does Canada—their health care costs by having plaintiffs' trial lawyers not be able to get the kind of settlements that you get here in the United States. That is not debatable.

Second of all, this Committee is—has been trying to—and it has held hearings on eliminating the not-for-profit exemption for public health facilities from being sued, literally going the other direction.

Third of all, it is within the purview of the Federal Government to demand that nobody charge more for prescription drugs or other benefits to a cash customer than they charge to anyone else.

We could make the cash payer the lowest payment, period, and we could mandate it under the law, and nobody could question the fact that nothing is more entitled to the lowest possible price than somebody walking in with U.S. currency that says "In God We Trust."

So all of those are ways that we can reduce the cost. And I guess I am getting some head-nodding, but I would like us to understand there should be alternatives, even to this Committee, that would, in fact, change the dynamics of people who live in fear that they are going to lose their house, their lifestyle, and end up living in a car over a health care cost.

Isn't it true that we could, in fact, do that?

And, Mrs. Edwards, I appreciate the fact that you were, rightfully so, saying, "Well, you know, what if we create a situation in which hospitals say they won't pay?" It is very clear that if we are going to limit recourse somewhat that we do have to have a back-stop so that our hospitals not fall away.

But isn't it true that, in fact, when the indigent go into our hospitals and they all receive care, ultimately the hospital either gets or doesn't get reimbursement from the government? But they don't make that determination when they walk in the front door. They make the determination after the care is given.

Mrs. EDWARDS [continuing]. Some uncompensated care that—provided by health care providers is in fact, paid for by the government under various programs, some paid by charities under their things, a large part paid by every single American.

Every insurance policy that we—that people have right now—\$1,100 extra is tacked onto that because we have cost-shifting.

Mr. ISSA. Oh, yes. We have even more of it with Medicare. That is very clear.

Mrs. EDWARDS. The cost-shifting that takes place—so the idea that we are not paying—that we are not paying anything because there are uninsured people in this country is wrong.

If you are insured in this country, you are paying \$1,100 a year. You multiply that by the number of policies across the country and you are going to have a really large number. And that kind of—a number like that could fix our health care program—our health care program entirely.

Mr. ISSA. Just for the record, I did see, I think, every head shaking yes, that if you walk in with green dollar bills you should get

the lowest price and not be, in fact, paying the highest price, while the government and every insurance company gets a lower price than the person that walks in with cash.

Mrs. EDWARDS. There are two things about this. One is we want to make certain that we are not disadvantaging someone who needs a medication but simply doesn't happen to—you know, they get paid on—they get paid on the—at the end of the month, and they happen to need the medication in the middle of the month. We want to make certain we are not disadvantaging them too much.

But if what we are saying is that competition and the influence of the dollar—that capitalism ought to work in—with respect to pharmaceuticals, you are going to get complete agreement here, which means that the largest customer of pharmaceuticals in the entire world, which is the United States government, ought not to be negotiating away or agreeing away, as Congress did with the prescription drug benefit for seniors, the ability to negotiate the lowest possible price.

Mr. ISSA. Look, I was just saying that if I walk in with hard, green \$20 bills, I ought to get the same price the government did get in that negotiation, which was done by every individual insurance company.

Is there anyone that would like to comment on the actual cash or cash equivalent statement?

Dr. WOOLHANDLER. Well, it seems like everyone ought to get the same price. Of course, that is what happens in a single-payer system, as everyone has the same insurance, and so the compensation for taking care of you is the same as taking care of me or Mrs. Edwards.

Mr. ISSA. When I walk up to United Airlines at the last minute and want a flight, I would like to get the lower price, too, but I don't.

Dr. WOOLHANDLER. Yes, but you have a choice about getting on the airplane. People don't have a choice about being sick.

Mr. ISSA. Okay. I am hoping I am down to two. Anyone like to answer the basic question of—

Mr. POTTOW. I am with you, Congressman. I think Dr., is that there is—the current pricing structure exploits the insurance coverage by charging—right, by charging more the other way, and so there is an arbitrage there.

Hardcore economists would say that is rational price discrimination. They can make more money that way. But I don't think that is necessarily in the best interest of minimizing the costs for everyone.

I don't want you to lose hope about your proposal with the non-recourse thing. You do need to somewhat iron out the works because it could devolve into simply voluntary debt, and that is not going to go over well with the hospitals.

But you could tweak it. You could try something like this H.R. 91 that say if you fall into certain categories—and we have to define the categories properly—if you fall into X, then there is a limit on what can be collected from you.

So maybe there is a different homestead exemption for someone who is, you know, going to lose the home for medical reasons. It is possible. It is conceivable. So there is something you could do.

Mr. ISSA. And that is, Mr. Chairman, what I was leading to, is the question of somewhere between no recourse except the house and absolute recourse in which they take everything, including the house would lie the question of whether or not the bankruptcy statute and, in fact, the whole debt process could proactively say that you cannot—that at some point the government becomes a back-stop against rising medical costs for our citizens.

Ms. MATHUR. Yeah, I think that—I mean, so that way you would be targeting exactly the people who actually need that system to work for them. I think that would tremendously contain costs.

Mr. POTTOW. I want to rain on your parade just one little bit, which is—and I think it is—an idea very worthy of following—

Mr. ISSA. Raining on my parade is how I get better ideas.

Mr. POTTOW. Okay. Well, so the way to do it would be maybe through the bankruptcy code through exemptions. You could create certain exemptions for medical people.

The raining is I understand—and you guys argue about this more than I do—that similar proposals were made as fixing mortgages through the bankruptcy system as well, and so that is a good way to do it. We can do it through the bankruptcy system.

And then I think that ran into resistance when people said, “No, no, no, we don’t want the bankruptcy judges getting involved in redoing the mortgages. That is a terrible idea.” So I just want to warn you that you may face some headwinds if you try to do that. But you have my support as a professor.

Mr. ISSA. I would mention that right now the cram-down provisions we are talking about are, in fact, not allowing someone to take their secured asset away. In this case, bankruptcy presently eliminates all the debt, 100 percent of the debt, to that category of creditor.

So anything we do that is in between actually doesn’t disenfranchise them. It simply keeps people from going into bankruptcy Chapter 7 when, in fact, we can more appropriately allow for a re-organization that does not wipe out the individual and yet, in an orderly fashion, would make those excess funds you could afford available but not have the—the house and the—and the lifestyle lost over—what Mrs. Edwards, rightfully so, said—this group of people who have chronic illnesses and find themselves beyond their original expectations they could have planned for.

Mr. COHEN. Mr. Issa, could you, for the Chair’s edification, summarize your proposed bill?

Mr. ISSA. Well, first of all, I think we do have the ability to deal with the fact that there are more different schedules for what somebody pays—if they walk into the hospital to get a CAT scan, they will pay four or five times as much for cash as the insurance companies pay or Medicare reimburses.

They will pay two, three, four, five times as much as what—for a prescription drug. And the truth is that the uninsured or those who are operating with medical savings accounts, what we might call self-insured, find themselves paying this huge premium. It unfairly drives people to insurance plans and, in fact, those insurance plans disconnect people.

So you know, my feeling is that I would like to embrace what Europe and Canada does, which is they limit the liability to the health care provider, which reduces the defensive medicine.

They do eliminate through single-payer—I don't actually buy into single-payer, but they do eliminate all cost-shifting, which is something that we have an obligation to do, to make sure that the costs are fairly attributed and not simply one group paying for another group without even knowing it.

And so you know, I do believe there is a lot of common, across-the-board—Chairman Conyers and I spent quite a bit of time one day here with Mr. Moore saying that we might disagree on the solutions, but we don't disagree on the problem.

Mr. COHEN. What I am asking—if there is anything particular in bankruptcy—are you suggesting that maybe medical debt should have—the government should be the—take those away from folks if they go to bankruptcy, or that the doctors or the health folks should not get as much opportunity to collect in bankruptcy as—if that is where you are going?

Mr. ISSA. I do, and because we have limited jurisdiction, what the backstop would be from the government would go to other Committees, but what we could do here is we could recognize that, if you will, a medical reorganization should be a short-form bankruptcy.

It should be a pleading to the court that here is my situation, I have a chronic illness, I am going to continue to have expenses which I cannot meet, my estate is now at a point where further—or I believe further taking from my lifetime savings, from my spouse's earnings and so on is inappropriate, and rather than simply throwing it all away and going on Social Security—or you see people divorcing sometimes to protect assets and to put the disabled person into a separate pool.

You see all kinds of tricks. I think we could work together to look at, if you will, a medical reorganization as a special class. And that falls within the jurisdiction and it presumes for a moment that we are not solving all the medical problems, but as a backstop against us not getting it all done in the next 2 weeks.

I certainly think that this Committee does have jurisdiction to look at that and to try to deal with the fact that it—that current bankruptcy does not always rightfully deal with what Mrs. Edwards said, which is you have these people with ongoing chronic illnesses, depleted savings, and why should we end up having them plead a bankruptcy after they have lost their house, after they are living in their car?

I think we can work together on that. And I think Mr. Conyers—it is something that this Committee has a real opportunity to do, which I think is different than the cram-down provision we were dealing with a few weeks ago.

I think this is something where you would get across the board wanting to make reorganizational bankruptcy short, simple and done at the most administrative level, so that we make sure we don't get conned, but at the same time we don't have people losing everything over a health care event.

Mr. COHEN. Thank you, Mr. Issa, for your surgically acute work here on this bankruptcy bill.

The gentleman from Iowa, Mr. King, is recognized.

Mr. KING. Thank you, Mr. Chairman.

I would suggest that the place to go to look for that model, picking up where Mr. Issa left off, would be Chapter 12, which was shaped here back during the farm crisis of the 1980's. And that is that same type of reorganization as to a specific class.

So I inject that into the record for consideration, which—I am just starting to think this through, listening to Mr. Issa.

But I have a series of questions that have emerged as I—since I began listening to the witnesses. And one of those is the discussion that was brought up by, I believe, Dr.—or Mrs. Edwards on cost-shifting, the \$1,100. It was you that testified—that \$1,100 cost on that.

And also, I think it was mentioned, perhaps by Dr. Woolhandler, but I am—I pose this question. Let's back up and pick a year—1970, for example.

If in that year this Congress had passed a Federal statute that prohibited cost-shifting, that everyone would get the same price for a service, just like today the rich and the poor pay the same price for gas, and without passing any national health care act but just simply changing that in 1970, and we would have had, then, these 39 years for that to evolve through the system, how do you think this system would look today if it hadn't been distorted by the cost-shifting that has emerged because of the limitations that came on the part of a number of—well, public providers, for example?

Mrs. EDWARDS. I have got to sort of preface this by an exception. Representative Issa was correct. If you are not insured, a great number of providers will charge you a higher price.

Perhaps if you came actually with the cash in hand they wouldn't, but if you were uninsured, they would charge you a higher price, assuming that they are not going to get 100 percent. Taking that—

Mr. KING. And I agree with—

Mrs. EDWARDS. Taking that—

Mr. KING [continuing]. Your assumption on \$1,100. That would be the number I would offer as well.

Mrs. EDWARDS. Yes, but I want to take that group out for a second and just assume that they are not going to collect anything from these people. It doesn't matter what they charged them. They are going to collect zero from this group of people who are uninsured.

That is not actually accurate. They will collect some, but assume that they are not. If you go back to 1970, you would still have cost-shifting. Even if everybody got exactly the same price, some people aren't going to pay, and therefore the provider, the hospital or the physician or the pharmacy or the—

Mr. KING. But, Mrs. Edwards, rather than respond with a new hypothetical, I would appreciate if you could just build this thing out if the one that I have offered were the only hypothetical we had to consider.

And I recognize some people won't pay, but of those that do pay, if they were billed the same price per service in all cases?

Mrs. EDWARDS. If they are billed—

Mr. KING. I am just saying—

Mrs. EDWARDS. If they are billed the same price for services, you would still have—you would still have cost-shifting, because right now there is a certain amount of money——

Mr. KING. Okay, thank you. I am——

Mrs. EDWARDS [continuing]. There is a certain amount of money that is coming in.

Mr. KING. That is not what I really am—the insight that I am looking for that I think you must have—perhaps Dr. Woolhandler will have an answer to that.

Dr. WOOLHANDLER. Okay. Well, using the term cost-shifting narrowly to talk about a price when you go to the hospital, that everybody has got the same price——

Mr. KING. Unit price identity.

Dr. WOOLHANDLER. There is this other concept of cost-shifting that is actually quite a bit more important, which is that when private insurers go out and try to get—recruit the healthiest people and cherry-pick, and then the sickest people get pushed off to other insurers or maybe to Medicare, or maybe they can't get insurance at all, and then the private insurance that did all the cherry-picking can go and shadow price the cost of insurance at Medicare or the other private insurance.

And that kind of cost-shifting that is sort of a patient shifting, if you will, cost shifts by getting rid of those expensive patients, and I might add you cost shift by getting rid of the doctors who take care of expensive patients. That is ubiquitous in the private health insurance system.

And just saying every C.T. scan costs 500 bucks doesn't fix that problem.

Mr. KING. Dr. Woolhandler, this is a very deep question that I have asked here, and I don't think we are going to be able to get to the bottom of it, so if you don't mind, I have a few more specific ones that I would like to ask instead.

And I would ask you, in the study that you participated in at Harvard, did you evaluate Chapter 11s as well as Chapter 7 bankruptcies?

Dr. WOOLHANDLER. No, we did Chapter 7s and Chapter 13s only.

Mr. KING. Okay. Thank you.

And are you aware or did you do a study on—have you seen data of doctors that have declared bankruptcy? Has there been any look at doctors that have declared bankruptcy?

Dr. WOOLHANDLER. My understanding is doctors declaring bankruptcy is very unusual. I have heard a few anecdotes of doctors who call me to tell me about it.

Generally it is because they became seriously and chronically ill themselves and even though they started with good health insurance ended up——

Mr. KING. Thank you. Does anyone——

Dr. WOOLHANDLER [continuing]. Losing——

Mr. KING. Does anyone on the panel have any knowledge of doctors that have declared bankruptcy?

Mr. POTTOW. Do you mean a business bankruptcy or a personal bankruptcy? Like a doctor inc?

Mr. KING. Either. Either. I am suggesting this, that if there was a doctor that for some reason wasn't covered by medical mal-

practice and there was a lawsuit, they might declare bankruptcy. So that surely has got to be a component of American society.

Mrs. EDWARDS. Usually that would be a business bankruptcy. But I mentioned earlier that I, in preparation for this hearing, talked to my former colleagues and—who practiced bankruptcy law and bankruptcy judges hearing cases and was told—and this is secondhand anecdotal—that certainly in the Eastern District of Virginia—Eastern District of North Carolina, we are seeing increased filings not just by individuals for a variety of reasons, but we are also seeing them by law firms, by medical practices as well.

So whatever the cause is, and we have had very few medical malpractice judgments in the last years in eastern North Carolina, so assume that these are caused by other reasons, but in any event, you are seeing some filings by bankruptcy attorneys.

Mr. KING. Well, thank you.

Mrs. EDWARDS. I mean by—

Mr. POTTOW. I am aware of one study, sir—

Mrs. EDWARDS [continuing]. By physicians.

Mr. POTTOW [continuing]. Which is that—which would probably explain why you won't see a lot of bankruptcies, which is that a lot of the malpractice actions against physicians themselves settle at the carriage—at the carrier coverage amount.

So it is picked up by their malpractice carrier.

Mr. KING. Well, and this is intriguing to me, in—let me see—Dr. Woolhandler's testimony, that 16.7 percent of the Canadian is spent on administrative fees. U.S.—I think you said 31 percent.

I know I have seen numbers that show 32 percent. So we are right in that same category there, and the data that has come out has been consistent with what I have seen.

But I would like to know what percent—first, you know, why the difference. What is that money being spent on, on administrative costs? I don't think I heard the answer to that.

And what percentage of our GDP is being consumed by malpractice insurance and litigation associated with that?

And could we then provide the medical equivalent of the sovereign immunity that government sometimes carries, and then just set up a fund to take care of the patients that might be victims of medical malpractice?

How much could we take out of the industry if we would just do those things that I have suggested?

And I think Dr. Woolhandler—

Dr. WOOLHANDLER. Sure. Well, I pay a big malpractice premium. I have luckily never been sued. But I am not very happy when I do get that bill.

But Canadian doctors do pay less for malpractice. Part of it is that no one ever has to sue for future medical expenses. So if you are a parent and your baby is born, you know, brain-damaged, you are looking at a million dollars in medical expenses when you are looking at that baby, and one—

Mr. KING. What part of the whole—

Dr. WOOLHANDLER [continuing]. Option if you have no way of paying is to sue the doctor. It is not right. It is not fair. But that is what happens in the U.S., and it never happens in Canada because medical expenses—

Mr. KING. Do you have an idea, though, on what part of the whole—what part of the 17.5 percent of the GDP is going off for medical malpractice premiums and the litigation opposing—Mrs. Edwards?

Mrs. EDWARDS. One-and-a-half percent of our medical costs are associated with medical malpractice premiums. Or the cost of medical—

Mr. KING. That is fine.

Mrs. EDWARDS [continuing]. Malpractice—1.5 percent—

Mr. KING. Okay.

Mrs. EDWARDS [continuing]. Of that 17 percent. So—

Mr. KING. Be about—

Mrs. EDWARDS [continuing]. We are talking about a—

Mr. KING.—8 percent?

Mrs. EDWARDS [continuing]. A fair—

Mr. KING. Oh. Well—

Mrs. EDWARDS. Oh, no, no. No, no. we are talking about point—probably .0—.0 something, .03.

Mr. KING. One-and-a-half percent of 17.5 percent.

Mrs. EDWARDS. Seventeen-and-a-half percent of GDP, and that is our—that is where we are starting. One-and-a-half percent of that 17.5 percent—

Mr. KING. Okay.

Mrs. EDWARDS [continuing]. So we are talking about something like point—these are the mathematicians down at the other end, but—

Mr. KING. Well—

Mrs. EDWARDS [continuing]. Something like .03.

Mr. KING. In that case, and that being an enlightening number, then, we will go back to the administrative question. Where is the money going in administration? Because that number does sound high to me.

Dr. WOOLHANDLER. Oh, administration is huge in the United States. The three biggest part of that—I mean, 31 percent is a lot of money. We are paying more than \$2 billion—\$2 trillion on health care, so we are talking \$700 billion annually in administration.

The three biggest components are the insurance overhead, so buying—selling the insurance; collecting all the premiums; underwriting, which is figuring out what patients or which groups of patients you are going to make money off of; fighting with the doctors and hospital about who pays the bills; trying to shift costs onto other insurance companies. That is the insurance over administration—insurance administration. That is the biggest—a big chunk.

Mr. KING. Do we have any—

Dr. WOOLHANDLER. The second largest—

Mr. KING [continuing]. Data on that? Is there any data?

Dr. WOOLHANDLER. Oh, yes. Yes. The New England Journal of Medicine, 2003. I am the first author, if you want to search for it.

Mr. KING. We need to visit that, and I just—if the Chair would indulge—just an opportunity for Dr. Mathur to provide a response to the discussion that we have had.

Mr. COHEN. Despite the fact that you were a terrible critic of my joke yesterday, you are indulged.

Ms. MATHUR. About the costs of—

Mr. KING. (Off mic.)

Ms. MATHUR. What was the exact question, what to do?

Dr. WOOLHANDLER. If you would like, just the other two components are the doctors' office administration, which is sky high, because we have to bill with literally hundreds, sometimes thousands, of different insurers, and collect all the co-payments.

Hospitals as well have huge administrative costs in the U.S. And all three areas—insurance administration, doctors and hospitals—are much lower in Canada, and be happy to supply you with that paper if you have trouble finding—

Ms. MATHUR. I—

Mr. KING. Dr. Mathur?

Ms. MATHUR. I just feel like the administrative—if the administrative costs are so huge under the current system, if we try to change the system to have basically more administration, I don't see how the costs are going to go down.

Mr. KING. If I could follow up with a question on that, too—and we didn't hear it addressed in any depth—that has to do with defensive medicine.

But I would think that 1.5 percent of 17.5 wouldn't—would be the premiums, but it wouldn't calculate the extra medical costs for defensive medicine, additional tests.

Dr. Mathur, could you address that?

Ms. MATHUR. I am not aware of data on that, but, you know, I—we could find, I guess—

Dr. WOOLHANDLER. There is literature on this if you—you can go and ask doctors, "How much of the medical care that you give are you doing for defensive reasons?" And those generate higher estimates than 1.5 percent, but not a whole lot higher, okay? It is a few percent—

Mr. KING. Thank you.

Dr. WOOLHANDLER [continuing]. Of total medical care costs.

Mr. KING. I appreciate all the witnesses. This has been an engaging—actually, a debate and a dialogue going in three directions here, and I get a lot out of that. I thank you.

And I yield back the balance of my time. Thanks, Mr. Chairman.

Mr. COHEN. Thank you, sir.

Mr. KING. And that was a bad—a lame joke. [Laughter.]

Mr. COHEN. I set the bar low for the—all the rest of comedy which you might be presented with for the week.

I would like to thank all the witnesses for their testimony today.

Without objection, Members will have 5 legislative days to submit any additional written questions which we will forward to the witnesses and ask that you answer as promptly as you can. They will be made part of the record.

Without objection, the record will remain open for the 5 legislative days for the submission of any other additional materials.

Again, I thank everyone for their time and patience and appreciate each of the witnesses. This has been a very lively and interesting debate. And the externalities were discussed as well.

This hearing of the Subcommittee on Commercial and Administrative Law is adjourned.

[Whereupon, at 1:27 p.m., the Subcommittee was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

RESPONSE TO POST-HEARING QUESTIONS FROM ELIZABETH EDWARDS,
SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS ACTION FUND

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on Medical Debt: Is Our Healthcare System Bankrupting Americans
July 28, 2009

Elizabeth Edwards, Senior Fellow, Center for American Progress

Questions from the Honorable Steve Cohen, Chairman

1. **In your September 2008 testimony to the Energy and Commerce Subcommittee on Health, you stressed that expanded health care coverage and cost control must go hand-in-hand. Do you think the approaches currently before Congress addresses each of these two issues adequately?**

The bills that have passed the House and the Senate, while they differ in important ways, share a commitment to increasing health insurance coverage through a combination of public program expansions, improvements to the health insurance market, financial help with premium costs, and an on-going role for employer-sponsored health insurance. Both bills also seek to control the growth in health care costs by, over time, changing how we pay for health care services – thus creating new incentives for managing chronic diseases, investing in prevention, and streamlining administrative costs.

Analysts disagree over whether the cost-containment provisions in one bill are more robust than those in another. Similarly, one bill provides greater premium and cost-sharing help to low- and moderate-income families – thus increasing the likelihood that these families are able to enroll in and maintain coverage.

Unaddressed in either bill are the collection techniques utilized to collect medical debt, which are in practice generally more aggressive than collection techniques utilized for collection of non-medical unsecured debts. Ideally medical debt collection would not be necessary with a fully-covered or nearly fully-covered population, but since aggressive collection techniques cause consumers to prioritize their debt payments in a manner that may not serve their interests, it may be worth -- in this legislation or fair debt collection or bankruptcy legislation -- to address this real life issue.

A significant portion of the costs in medical care are necessitated because we have too many different fee structures in place. Nearly every means of payment utilized around the world for paying for health care is utilized in the United States, from government provision of services to government payments for services to non-profit private health insurance companies and for profit private health insurance companies to individual financial responsibility for their health care costs. And in a single venue, the fee schedules can vary widely and across the country there are even wider variations. There is no more expensive way to provide health care to our citizens. In addition the actual costs are hidden and patients, and even health care professionals, do not know the cost a particular patient will be billed for a particular procedure. An insured individual is likely to be billed a multiple of what an insured individual can pay. Under Medicare rules on reimbursement to providers of pharmaceuticals, large providers who can negotiate lower prices can make money on pharmaceuticals when smaller providers actually lose money on that service. Review and oversight that places patient care and cost efficiency as the priorities will result in better care and lower health care costs overall.

We will soon see which provisions emerge in final legislation. As I noted in my testimony, coverage and cost-containment are two sides of the same coin. It is my hope that the final bill will be able to maximize coverage expansions and prompt aggressive efforts to control costs. It will also be critically important that health reform implementation efforts move aggressively on delivery system reforms, thus delivering on both of these promises.

2. What changes to the 2005 bankruptcy code amendments would you make in order to help solve the problem of medical bankruptcies?

Medical debtors should not be required to go through credit counseling unless the Trustee requests it and the bankruptcy judge orders it. There may be instances when a medical debtor has additional credit issues that need counseling, but in large part these debtors are not in bankruptcy because of voluntary action or inaction. There was some discussion about whether the counseling was onerous or not, but that is completely beside the point. It is unnecessary; it adds to the expense of bankruptcy.

Bankruptcy judges should be given latitude on how to treat medical debt and whether to allow filing of a Chapter 7 or conversion to a Chapter 7 for debtors with significant medical debt. Given differing family situations and the need for additional medical care, the greatest degree of latitude (on what constitutes significant medical debt) that could be afforded would be the ideal. Requiring bankruptcy judges to make written findings of significant medical debt and making such an order immediately appealable should eliminate any fears of those who suggest that medical debt is a vapor. Bankruptcy judges would be in the best position to determine what portion of other debts -- second mortgages, credit card debt -- are actually medical debt. A formula offered from any distance is less likely to cure the ill that the Committee seeks to address.

3. Should studies on medical debt as a contributor to bankruptcy also account for those carrying substantial medical debt who have not filed for bankruptcy?

Current studies on medical bankruptcy -- and foreclosure driven by medical debt -- are based on survey data of individuals who have filed for bankruptcy or whose property is in default. In both scenarios the names and addresses of these debtors are publicly available, which facilitates survey methods targeted to these individuals. It would be useful for policymakers to know how many more individuals and families are struggling with high medical debt, if researchers can develop a practical approach to finding and surveying these debtors. An alternative strategy would be to add questions on medical debt to existing large surveys that explore issues related to medical spending, such as the HSC Health Tracking Household Survey, or AHRQ's MEPS survey. In many other areas we extrapolate figures to account for the unmeasured subject; in this area, those people who have no public filing identifying their dilemma who are nonetheless living on a razor's edge caused by medical debt are worth our attention, too.

4. If there are any additional points you wish to make--by way of elaborating upon your hearing testimony or responding to the testimony of other witnesses--please do so.



RESPONSE TO POST-HEARING QUESTIONS FROM STEFFIE WOOLHANDLER, M.D.,
M.P.H., PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on Medical Debt: Is Our Healthcare System Bankrupting Americans
July 28, 2009

Steffie Woolhandler, M.D., M.P.H., Harvard Medical School

Questions from the Honorable Steve Cohen, Chairman

- 1. Could you estimate the absolute number of Americans who are medically bankrupted each year?**

About 1.4 million bankruptcies are expected in 2009. If 62.1% of bankruptcies are due at least in part to medical illness or medical bills, we'd estimate about 869,000 medical bankruptcies this year.

- 2. Is it possible to break down your data by region, to see whether certain locales have a higher proportion of medical bankruptcies than others?**

No. We have insufficient sample size to confidently assess rates in cities or counties. It is possible to look at larger states, although confidence intervals (also known as the margin of error) would be quite large. Our total sample size was about 2300 or about 46 cases per state, on average.

- 3. Some critics of your study have suggested that emphasizing the proportion of medical bankruptcies is really not useful analytically and that your study should have focused on the fact that the absolute number of medical bankruptcies, which have fallen since 2001. How do you respond to these points?**

We believe that the increasing share of bankruptcies attributable to medical illness is an indicator that health care problems are playing an increasing role in the financial distress of American families. The overall rate of bankruptcy in the U.S. has bounced up and down due primarily to changes in the federal bankruptcy law. Specifically, the U.S. Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which took effect in October of 2005. BAPCPA instituted an income screen and erected several procedural barriers to filing, making bankruptcy filing more difficult and expensive. The number of bankruptcy filings spiked in mid-2005 in anticipation of the new law, then plummeted when the law took effect. Since then, filings have increased steadily. If BAPCPA had selectively discouraged non-medical bankruptcies, that would provide an alternative explanation of our finding that medical bankruptcies increased as a share of total bankruptcies.

However, we found no evidence from our data that BAPCA's effects had been selective. The income and other financial characteristics of households in bankruptcy changed little between 2001 and 2007, except that families in bankruptcy—like their counterparts outside bankruptcy—are carrying larger debt loads. The bankrupt population has also continued to age (continuing a trend that dates to 1991), but other demographic characteristics – gender, education, household size, occupational prestige – remained stable between 2001 and 2007. Bankruptcy filers in 2007 differed from those of the past mainly in having struggled longer with their debts, contributing to the credit industry's rising profits. The changes implemented under BAPCA – restrictions, delays, and added financial burdens – fall equally on medical and non-medical bankrupts. BAPCA granted no preferences to medical debts nor to ill or injured debtors. Hence, we believe it is implausible to ascribe the growing predominance of medical causes of bankruptcy to BAPCA.

Conversely, there is ample evidence that the financial burden of illness, and particularly chronic illness, is increasing. Since 2001, health care costs have risen substantially (even adjusted for inflation) and the ranks of the uninsured have swelled by several million. As employers trimmed health benefits, the number of under-insured (i.e. persons having some insurance, but still facing huge medical bills if they experience a major illness) increased from 15.6 million in 2003 to 25.2 million in 2007. For instance, among those with employer-sponsored coverage, nearly half of the top decile of health care utilizers spends at least 15% of income on uncovered health costs.

Of low and middle income households with credit card balances, 29% are using credit card borrowing to pay off medical expenses over time; these same households have credit card balances 46% higher than those without medical debts. 37.2 million Americans were contacted by a collection agency regarding a medical bill in 2003. Between 2005 and 2007 the proportion of non-elderly adults reporting medical debts or problems paying medical bills rose from 34% to 41%. These data offer indirect evidence that rising out-of-pocket costs (rather than changes due to BAPCA) are responsible for the increasing share of bankruptcies.

4. You have written extensively on the amount of administrative waste generated in our health system by the need for doctors and hospitals to fight with insurance companies over payment. Can you comment on administrative waste related to providers hiring collection agencies to collect medical debt?

We have no data on the specific administrative costs related to the hiring of collection agencies.

If there are any additional points you wish to make—by way of elaborating upon your hearing testimony or responding to the testimony of other witnesses—please do so.



RESPONSE TO POST-HEARING QUESTIONS FROM JOHN A. E. POTTOW,
PROFESSOR OF LAW, UNIVERSITY OF MICHIGAN LAW SCHOOL

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on Medical Debt: Is Our Healthcare System Bankrupting Americans
July 28, 2009

John A. E. Pottow, Professor of Law, The University of Michigan Law School

Questions from the Honorable Steve Cohen, Chairman

1. **You noted that most elder Americans are supposed to be covered by Medicare, yet your research has shown that a growing proportion of bankruptcy filers are over 65 and that medical reasons appear to be a driving force behind that phenomenon. Why do you think this is the case?**

There could be multiple things going on with Medicare. It could be, as Dr. Woolhandler implies, that sometimes mere health insurance is not enough (due to premiums, deductibles, coverage limits, etc.) to prevent medical bankruptcies. Accordingly, it could be that Medicare itself is an insufficiently protective insurance scheme, an unpopular observation I can somewhat evade by saying I am not fully familiar with how that program works. It could also be that there are other medical issues – for example, drug coverage – that Medicare doesn’t cover enough. It could also be – and this is my own hypothesis that I’ve been working on but only conjecture at this point – that as elder Americans are finding it harder and harder to get by on social security and diminishing pensions (recall that many have to purchase so-called “Medigap” policies to make up for what Medicare won’t cover and that those premiums are rising fast), they are driven back into the workforce but unable to find sufficient income to make ends meet.

In fact, in my study of elder bankrupts, I found 33% of those retired had to go back into the workforce. Similarly, I found for those respondents age 65 or over who were still working or seeking work, only 36% were doing so because they enjoyed working. Most (74%) cited the need for more money to cover everyday expenses; 15% specifically said they did so for needed health insurance benefits; and 18% said they did so to pay for healthcare and medical expenses. (These numbers are non-cumulative; because you can answer more than one reason the totals will be more than 100%.) What this means to me is that it could be when a health problem hits, it’s not just the medical bills that put people into bankruptcy (which Medicare should help), it’s that they can’t work as many hours and so their income drops (which Medicare can’t help). But this is still ongoing work. I note also that the prevalence of Medigap policies suggests to me there is much that Medicare doesn’t cover. Here are some data on Medigaps from my research: around two-thirds of elder bankrupts had a Medigap policy, and 1/3 of those people had to pay the full cost of that policy themselves. (Some employers paid for Medigap policies as a retirement benefit: 13% of policyholders in my study said their employer paid for such a policy completely and 15% said the employer paid for part.) Finally, of my bankrupt elders, 20% said they found the Medicare premiums and co-pays “very much” difficult to pay before bankruptcy and another 20% found them “somewhat” difficult to pay – a minority of 40% but a pretty sizable minority of bankrupt Medicare beneficiaries.

2. Other than eliminating the means test or those measures proposed in H.R. 901, are there any changes to the Bankruptcy Code that you believe might provide a better measure of relief for those who are forced into bankruptcy because of high medical debt?

I know the Senate analogue of H.R. 901 had some other ideas, such as minimum homestead exemptions and attorney fee non-dischargeability (which would help fund ch. 7s). There are also other generally beneficial changes to the Bankruptcy Code that would indirectly help medical debtors (e.g., mortgage modification), but I understand there are political constraints on such proposed amendments. Then again, I don't see why one couldn't have a carve-out and allow mortgage modification for medical debtors. You probably don't want to redesign the Code yet, but another idea might be to have a separate "chapter 14" proceeding, just for medical debtors, which allows a quick wash of their debts and fixing of their mortgages (if necessary) that could be done in a few months. That, however, is just throwing out an idea, and maybe beyond the scope of your current interest.

3. If there are any additional points you wish to make—by way of elaborating upon your hearing testimony or responding to the testimony of other witnesses—please do so.

I think the hearing was pretty comprehensive (and I commend the committee). Obviously, I disagree with the research focus of Dr. Mathur and others of her ilk, both for the specific conclusions they raise on the limited relevance of medical bankruptcies and of the general methodological belief that survey evidence of the type of the Harvard study is somehow inferior to regression analysis of large datasets. I think both Dr. Mathur and I would agree that the "gold standard" for statistical estimation of causation would be double-blind random assignment to treatment and control groups (think of a medical test where half get placebo and half get control). But nothing of that sort of precision is possible in measuring a sociological phenomenon like the prevalence of medical bankruptcies. Dr. Mathur thinks the second best is a regression, where you look at a bunch of different characteristics (income, demographics, etc.) as independent variables and see if they correlate with a dependent variable (filing for bankruptcy). If you "control for" many variables and find that medical debt alone correlates significantly with bankruptcy, then you can impute by this correlation (but not really prove) causation.

That's fine and well, in theory, and I have indeed run many a multiple linear regression myself in other academic works. But you have to have great confidence in the coding of the underlying variables that comprise the dataset. For example, the so-called medical debts must be (a) truly medical debts, and (b) all the medical debts. The surveys she relies upon are simply unreliable in this regard; as she herself admits, they categorize a credit card debt as a different and distinct debt from a medical debt (and hence exclude all credit card debts when running the so-called "medical debt" regressions).

The alternative in such an imperfect world is survey evidence – actually asking real human beings who went bankrupt what happened and to tell their stories. That's what the Harvard study does. There are limitations with this methodology, of course – as with all methodologies – such

as sample bias (you've picked an unrepresentative group to answer the questions) or response bias (they're lying in their answers). For the reasons in the methodological appendix published alongside one of the studies coming out of the Harvard data, I feel comfortable that sufficient sample bias checks were done to make the findings reliable. And for previously published reasons on this sort of bankruptcy data, I also feel comfortable that respondents are being candid. By contrast, the only survey data Dr. Mathur cited, the question "Have you ever gone bankrupt?" was answered at a rate that was half of what we know to be the real bankruptcy rate in the population (based on public court data). This means that survey either had a sample bias or, more likely, a response bias because respondents thought they could hide their bankruptcies from the researchers, who were asking them myriad questions about all sorts of financial issues (in contrast to the Harvard study which was just drawn from known bankrupts).

I don't want to overstate the case of our methodological perfection. Rather, I just want to emphasize that we are doing the best we can as researchers and have had our findings published in peer-review journals (which scrutinize methods in their vetting process). No study is perfect. To the extent Dr. Mathur suggests a hierarchy of methodological approaches, she is mistaken, other than in the general observation that randomized double-blind is preferable – which everyone agrees is impossible here. Indeed, I confess being surprised how much "attention" the Harvard study has come under. Very few research projects I have ever been associated with have escaped criticism – that is the nature of the academic exercise – but the "cottage industry" of attacks that this study has spawned seems so unprecedented that one can only wonder skeptically of its provenance.

Finally, I would like to reiterate a point from my oral testimony: dithering over nailing down the exact percentage of "medical bankruptcies" is in part a fool's errand. First, we will never know with absolute, epistemic certainty whether it is 54% or 34% or 53.1415926% – we are estimating the prevalence of a sociological phenomenon of an inherently imprecise nature. Second, for purposes of Congress deciding to reform healthcare and bankruptcy laws, such precision is not only unattainable, it is probably of limited help. Whatever the metric used (whether we define medical bankruptcy as over \$1,000 in medical debts or \$5,000 or 10% of income), all measures lead to a rate that is too high in an economically developed nation. Were, for example, Dr. Mathur ever able to convince me that a more accurate estimate of medical bankruptcies were 30% instead of the currently discussed numbers, my policy reactions would remain unchanged. Far from being a "gotcha," I would see this as still a reflection that a sizable percentage of debtors are filing for bankruptcy for reasons that are the result of losing life's lottery. While any system will have unfortunate cases, we should hope they are only a trivial number. And I don't think anyone, even Dr. Mathur, would characterize the number of medical bankruptcies – by whatever metric one chooses – as "trivial." That is why Congress's attentions are needed to help in this area, and I continue to wish its members good luck.

