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# Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts

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## ARTICLES

### RETHINKING THE DEBATES OVER HEALTH CARE FINANCING: EVIDENCE FROM THE BANKRUPTCY COURTS

MELISSA B. JACOBY,\* TERESA A. SULLIVAN\*\*  
& ELIZABETH WARREN\*\*\*

*In 1999, Professors Jacoby, Sullivan, and Warren undertook an empirical study of bankruptcy filings to understand better the circumstances that brought middle-class families to a state of financial collapse. The information gathered in the study, known as Phase III of the Consumer Bankruptcy Project, revealed that an estimated more than half a million middle-class families turned to bankruptcy courts for help after illness or injury that year. The findings of the study illustrate how bankruptcy files document the economic problems families encounter when bills mount and incomes fall in the aftermath of a medical problem. In this Article, Professors Jacoby, Sullivan, and Warren present the data from their study to illustrate that hundreds of thousands of middle-class families in the United States are devastated economically each year under the current health care finance system. Their data indicate that focusing on the presence or absence of health insurance alone would lead to an incomplete solution. Instead, the authors suggest that since bankruptcy effectively serves as part of the health care payment system, bankruptcy policy should be included in any comprehensive review of health care financing policy.*

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Bankruptcy is the ultimate declaration of financial collapse for middle-class Americans.<sup>1</sup> Notwithstanding the occasional anecdote of a high roller who glides into bankruptcy with a cache of assets in offshore trusts or with a fancy house held in the name of a family member, the typical family in bankruptcy is in desperate financial condition.<sup>2</sup> These families arrive at the bankruptcy courthouse exhausted emotionally and financially, hoping that the opportunity to discharge some debts and restructure others will help to stop the collection calls, save their homes or their cars from foreclosure and repossession, and give them the chance to stabilize their economic circumstances.

In 1999, we undertook an empirical study of the families in bankruptcy with the express goal of better understanding the circumstances that brought these middle-class families to a state of financial collapse. Our study, which is discussed in the Appendix in greater detail, constitutes Phase III of the Consumer Bankruptcy Project<sup>3</sup> and surveyed

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ied. We particularly thank the Honorable Edward Jellen, Chief Judge, Bankruptcy Court for the Northern District of California; the Honorable Robert Ginsberg, Judge, Bankruptcy Court for the Northern District of Illinois; the Honorable Joe Lee, Judge, Bankruptcy Court for the Eastern District of Kentucky; the Honorable Barbara Sellers, Judge, Bankruptcy Court for the Southern District of Ohio; the Honorable David Scholl, Judge, Bankruptcy Court for the Eastern District of Pennsylvania; the Honorable Keith Lundin, Judge, Bankruptcy Court for the Middle District of Tennessee; the Honorable John Akard, Judge, Bankruptcy Court for the Northern District of Texas; and the Honorable Robert Martin, Chief Judge, Bankruptcy Court for the Western District of Wisconsin. The judges and their staffs offered critical assistance to this project.

Some of the material presented in this Article originally appeared in Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Medical Problems and Bankruptcy Filings*, Norton Bankr. L. Adviser, May 2000, at 1. That material is reproduced with the permission of the copyright holder, West Group.

<sup>1</sup> See Teresa A. Sullivan, Elizabeth Warren & Jay Lawrence Westbrook, *The Fragile Middle Class: Americans in Debt* (2000). The research reported in Sullivan, Warren & Westbrook, *supra*, as well as other studies by the same authors, reveals that debtors in bankruptcy are slightly better educated, work in about the same jobs and industries, and enjoy about the same occupational prestige as Americans generally. Although their reported annual incomes are substantially lower than the median income in the United States at the time of their filing, the debtors themselves often have experienced an income interruption in the period before filing that depresses their earnings. For a more detailed discussion of the demographic and economic status of the debtors, see *id.* at 27-74.

<sup>2</sup> The median annual income for consumer debtors in our sample was \$28,000. The median ratio of total debt to total income, built on a debtor-by-debtor basis, was 1.4, which means that the middle debtor in our sample owed nearly one and one-half years' worth of income to his or her creditors. The reports of the serious financial trouble facing most debtors in bankruptcy are confirmed in earlier studies as well. See, e.g., Elizabeth Warren, *The Bankruptcy Crisis*, 73 *Ind. L.J.* 1079, 1095-1100 (1998) (describing incomes and debt-to-income ratios of debtors according to earlier studies).

<sup>3</sup> Phase I of the Consumer Bankruptcy Project analyzed petitions of debtors filing for bankruptcy in 1981 in ten judicial districts located in three different states. See Teresa A. Sullivan, Elizabeth Warren & Jay Lawrence Westbrook, *As We Forgive Our Debtors:*

1974 individual debtors during the first quarter of 1999 in eight federal judicial districts around the country. The survey questionnaire was broad in scope and included questions about medical problems, medical debts, and health insurance.

In the course of this study, we discovered the findings that prompted this Article—namely, that many families declared bankruptcy in the aftermath of illness or injury and that the bankruptcy system may be an overlooked source of information for purposes of the health care finance policy debates. In this Article, we consider the extent to which middle-class families have used bankruptcy as a safety net, or as insurance of last resort, in the financial aftermath of medical problems.

Extrapolating from the questionnaire data, we estimate that more than half a million middle-class families turned to the bankruptcy courts for help following a illness or injury in 1999.<sup>4</sup> Nearly half of *all* bankruptcies involved a medical problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report a health-related bankruptcy. We also found that the families in bankruptcy with medical problems are not drawn exclusively from among the uninsured. About eighty percent had some form of medical insurance, suggesting that basic health insurance coverage does not insulate families from financial catastrophe when they suffer serious medical problems. Families may face medical bills that outstrip basic insurance coverage, or they may discover that the income effects, such as lost time from work or a shift to less physically

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Bankruptcy and Consumer Credit in America 18 (1989). Phase II of the project used questionnaire data from petitioners filing for bankruptcy in 1991 in sixteen federal judicial districts located in five different states. See Sullivan, Warren & Westbrook, *supra* note 1, at 7. In Phase II, questionnaire data were linked to court petition data for debtors in five districts, one in each of the states that was studied. *Id.*

<sup>4</sup> See *infra* fig.3. Estimates are calculated using the number of reported individual filings during 1999 and multiplying that number by the percentage of debtors giving a particular response in the 1999 survey. The number of nonbusiness Chapter 7 and Chapter 13 filings in 1999 was 1,280,875. See News Release, Admin. Office of the U.S. Courts, Bankruptcy Filings Down in Calendar Year 1999 (Mar. 3, 2000), [http://www.uscourts.gov/Press\\_Releases/cy99bk.pdf](http://www.uscourts.gov/Press_Releases/cy99bk.pdf). We added 5903 Chapter 13 filings designated as “business” because they were filed by live human beings and are therefore within the universe of debtors we sampled. We multiplied the proportion of debtors in each category by the resulting figure of 1,286,778 cases. We have no way to estimate the number of Chapter 7 filings by individuals designated as “business” cases, which means that we necessarily omit all “business Chapter 7” cases from the denominator of the calculation. Similarly, we omit all individual Chapter 11 filings and all Chapter 12 filings. As a result, these data understate to some degree the precise number of individuals filing for bankruptcy to deal with medical problems. In order to avoid the appearance of false precision, we round off our estimates to the nearest 10,000.

demanding work, impose a financial hardship on a family that basic medical insurance simply does not cover.

The data presented here are important for reframing some of the debates over financing health care. These data suggest that literally hundreds of thousands of families are devastated economically each year under our current system of financing health care. The data also indicate that focusing solely on the presence or absence of health insurance would lead to an incomplete solution. The high proportion of families with health insurance who are filing for bankruptcy in the aftermath of medical problems invites the exploration of a more comprehensive approach to evaluating the costs of medical care, including a consideration of the income effects of illness and accident.

In Part I, we examine studies previously conducted on the connection between medical problems and bankruptcy. In Part II, we analyze our medically related findings from the 1999 survey. In Part III, we explore the implications of the findings for the health care finance policy debate, and we consider potential explanations for the prevalence of medically related bankruptcies in the United States. Finally, in Part IV, we explore the policy implications of the study's findings on both the health care finance and the bankruptcy systems.

## I

### STUDIES OF BANKRUPTCY AND MEDICAL PROBLEMS: 1960s-1990s

The role of medical debt and other health-related problems in causing the financial collapse of families has appeared in earlier studies of the bankruptcy system. Until the 1990s, however, most empirical studies of bankruptcy did not find illness, injury, or medical debt to be a major cause of bankruptcy. For example, a single-district study in New York found that health care costs constituted less than two percent of the scheduled debts in bankruptcy.<sup>5</sup> Similarly, in a Nebraska case study in the 1960s, the physician-authors found that medical debts were not significant in consumer bankruptcy cases.<sup>6</sup> Table 1 summarizes a series of empirical studies that began in the 1960s, some of which appeared in the medical, rather than legal, literature.

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<sup>5</sup> Barry A. Gold & Elizabeth A. Donahue, *Health Care Costs and Personal Bankruptcy*, 7 *J. Health Pol. Pol'y & L.* 734, 736 (1982).

<sup>6</sup> Larry Sittner et al., *Medical Expense as a Factor in Bankruptcy*, 52 *Neb. St. Med. J.* 412, 416-17 (1967).

TABLE 1: RESULTS OF PREVIOUS EMPIRICAL STUDIES OF MEDICAL ISSUES AND PERSONAL BANKRUPTCY

Date of Bankruptcies	Geographic Area	Percent of Debtors with Medical Debt	Percent of Debtors with Medical "Cause" of Bankruptcy	Study Authors
1964	8 Districts		11%	Stanley & Girth (1971) <sup>7</sup>
1978	N.D.N.Y.	64.1%	<3%	Gold & Donahue (1982) <sup>8</sup>
1965	D. Neb.	81.4%	Not significant	Sittner et al. (1967) <sup>9</sup>
1979-1981	9 States	56%	"Majority"	Shuchman (1983) <sup>10</sup>
1980	National (?)		30%	Domowitz & Sartain (1999) <sup>11</sup>
1981	10 Districts	52%	2%	Sullivan, Warren & Westbrook (1989) <sup>12</sup>
1981	W.D. Tex.		8%	Sullivan, Warren & Westbrook (1989) <sup>13</sup>
1982-1983	D.N.J.	46%		Shuchman (1985) <sup>14</sup>
1975-1985	C.D. Cal.	80%	25-30%	Russell (2000) <sup>15</sup>
1985	E.D. Tenn.		50%	Kovac (1991) <sup>16</sup>
1991	16 Districts		20%	Sullivan, Warren & Westbrook (2000) <sup>17</sup>
1991	W.D. Tex.		14%	Sullivan, Warren & Westbrook (2000) <sup>18</sup>
1996	?		16.5%	VISA (1996) <sup>19</sup>
1997	S.D. Ohio		21.4%	Sellers (2000) <sup>20</sup>

Note: Methods of measurement vary; see text.

One major study during this period, conducted by researchers from the Brookings Institution, studied personal bankruptcy cases that were closed in 1964 from seven federal judicial districts.<sup>21</sup> When

<sup>7</sup> David T. Stanley & Marjorie Girth, *Bankruptcy: Problems, Process, Reform* (1971).

<sup>8</sup> Gold & Donahue, *supra* note 5.

<sup>9</sup> Sittner et al., *supra* note 6.

<sup>10</sup> Philip Shuchman, *The Average Bankrupt: A Description and Analysis of 753 Personal Bankruptcy Filings in Nine States*, 88 *Com. L.J.* 288 (1983).

<sup>11</sup> Ian Domowitz & Robert L. Sartain, *Determinants of the Consumer Bankruptcy Decision*, 54 *J. Fin.* 403 (1999).

<sup>12</sup> Sullivan, Warren & Westbrook, *supra* note 3.

<sup>13</sup> *Id.*

<sup>14</sup> Philip Shuchman, *New Jersey Debtors 1982-1983: An Empirical Study*, 15 *Seton Hall L. Rev.* 541 (1985).

<sup>15</sup> See Sullivan, Warren & Westbrook, *supra* note 1, app. 1 at 282-83 (discussing unpublished study by Judge Barry Russell).

<sup>16</sup> Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 *Am. Bankr. L.J.* 675 (1991).

<sup>17</sup> Sullivan, Warren & Westbrook, *supra* note 1.

<sup>18</sup> *Id.*

<sup>19</sup> VISA U.S.A. Inc., *Consumer Bankruptcy: Bankruptcy Debtor Survey* (1996).

<sup>20</sup> See Sullivan, Warren & Westbrook, *supra* note 1, app. 1 at 283-84 (discussing unpublished study by Judge Barbara Sellers).

<sup>21</sup> Stanley & Girth, *supra* note 7, at 48-69.

interviewed about the immediate cause of their bankruptcy filings, eleven percent of the sample responded "poor health," "babies," or "death in family."<sup>22</sup> A broader interview question about the underlying causes of bankruptcy found that about twenty-eight percent of the debtors cited family health reasons (sickness, injuries, babies, and death) as the problems that had placed them in financial difficulty.<sup>23</sup> This group of reasons was second only to a set of reasons titled "poor debt management," which included too many debts, unwise financing, and overspending.<sup>24</sup>

During the 1970s, there appeared to be greater concern that medical costs were playing a role in personal bankruptcy.<sup>25</sup> In his nine-state study of bankruptcy schedules in cases filed between 1979 and 1981, Philip Shuchman found that about fifty-six percent of the case files listed medical debts among the debtors' obligations. Shuchman concluded that, "ordinarily[,] unanticipated medical expenses play a major role in the family finances of more than half the personal bankrupts."<sup>26</sup> In a later study focusing on cases filed in New Jersey, Shuchman found that forty-six percent of cases he studied had medical debt, and that medical debt comprised twelve percent of total unsecured debt for those who had medical debt.<sup>27</sup>

Studies exploring the link between medical costs and personal bankruptcy filing continued during the 1980s. In Phase I of the Consumer Bankruptcy Project, Teresa Sullivan, Elizabeth Warren, and Jay Westbrook studied bankruptcy petitions filed in ten federal judicial districts during 1981.<sup>28</sup> They concluded that catastrophic medical losses were the cause of bankruptcy for about one to two percent of the debtors, although over half the debtors listed some medical debt in their bankruptcy files.<sup>29</sup> Medical debt accounted for about eleven percent of all scheduled unsecured debt.<sup>30</sup> The range among debtors was enormous, however, with debtors listing medical debts ranging from a negligible amount to all of the outstanding debt.<sup>31</sup> In the Western District of Texas, a district included in the study, local court rules

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<sup>22</sup> Interviewees could give multiple answers to the question about the "immediate cause" of bankruptcy. The published responses merged the answers into the categories of "poor health," "babies," or "death in family." *Id.* at 48.

<sup>23</sup> *Id.* at 47.

<sup>24</sup> *Id.*

<sup>25</sup> See, e.g., H.R. Doc. No. 93-137, pt. 1, at 55 (1973) (evaluating state of bankruptcy system and users of bankruptcy).

<sup>26</sup> Shuchman, *supra* note 10, at 295.

<sup>27</sup> *Id.* at 571.

<sup>28</sup> See *supra* note 3.

<sup>29</sup> Shuchman, *supra* note 10, at 168, 173.

<sup>30</sup> *Id.* at 168.

<sup>31</sup> *Id.*

mandated that, in addition to the bankruptcy petition listing all debts, all debtors file responses to an interrogatory that included a question about the causes of the bankruptcy. In the 1981 sample drawn from this district, eight percent reported a medical reason for their bankruptcy filings.<sup>32</sup>

Using an empirical qualitative choice model based on bankruptcy case data from 1980, Ian Domowitz and Robert Sartin found that health problems leading to "medical debt ha[d] the greatest single impact of any household condition in raising the conditional probability of bankruptcy. . . . Households with high medical debt exhibit a filing probability greater than 28 times that of the baseline."<sup>33</sup> They noted that their conclusion implied that "for an 87 million household economy, about 233,000 households could be declaring bankruptcy based on medical debt alone, which is approximately 30% of debtors in 1994, for example."<sup>34</sup> An Eastern District of Tennessee study in the mid-1980s found a dramatically higher prevalence of medical debt in bankruptcy.<sup>35</sup> This study was limited to judgment-proof debtors, that is, debtors who had no assets from which creditors potentially might benefit.<sup>36</sup> This sample represents some of the economically worst off of all bankruptcy debtors, the poorest of an already hard-pressed group. Susan Kovac found that eighty percent of the debtors owed some medical debt and that medical debt was forty-two percent of total unsecured debt and eighty-five percent of the previous year's income of the debtor.<sup>37</sup> Kovac concluded that medical debt was the "driving force behind these bankruptcy petitions."<sup>38</sup>

In Phase II of the Consumer Bankruptcy Project, Sullivan, Warren, and Westbrook used questionnaire data from bankruptcy petitioners who filed in sixteen federal judicial districts during 1991.<sup>39</sup> In answer to an open-ended question about the reasons for bankruptcy, the national sample showed that 19.3% identified a medically related problem as a reason for their bankruptcy filings.<sup>40</sup> In the Western District of Texas, where eight percent had reported a medical reason for their personal bankruptcy filings a decade earlier, fourteen percent of the sample reported a medical reason in 1991.<sup>41</sup> If the birth, death,

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<sup>32</sup> Sullivan, Warren & Westbrook, *supra* note 1, at 166.

<sup>33</sup> Domowitz & Sartin, *supra* note 11, at 413.

<sup>34</sup> *Id.*

<sup>35</sup> Kovac, *supra* note 16, at 684, 751.

<sup>36</sup> *Id.* at 676.

<sup>37</sup> *Id.* at 712-13.

<sup>38</sup> *Id.* at 713.

<sup>39</sup> Sullivan, Warren & Westbrook, *supra* note 1, at 7.

<sup>40</sup> *Id.* at 269, 330.

<sup>41</sup> *Id.* at 167.



and medical reasons reported in Phase II of the Consumer Bankruptcy Project were recombined in a manner parallel to the approach used by the Brookings researchers in the 1960s, then about thirty-seven percent of the 1991 sample could be said to have had a birth, death, or health reason for the bankruptcy.

Most studies during the 1990s continued to identify a substantial fraction of debtors citing medical reasons for their bankruptcies. Of the debtors answering a question in a 1996 VISA U.S.A. survey about the main reason that they had to file for bankruptcy, 16.5% identified medical and health related explanations.<sup>42</sup> The respondents also were asked about the “last straw” that led to their bankruptcy filings, to which 14.3% of the respondents identified medical problems.<sup>43</sup> More than one-fifth of a sample of bankrupt debtors in the Southern District of Ohio said they were in bankruptcy for medical reasons.<sup>44</sup> By contrast, in an economic analysis based on retrospective answers to a question about having filed bankruptcy, Scott Fay, Eric Hurst, and Michelle White concluded that health problems for the head of household or for the spouse during the previous year did not have a statistically significant effect.<sup>45</sup>

Long cited anecdotally as a reason for financial collapse, medical problems have appeared and reappeared in most empirical studies of consumer bankruptcy, but with substantial variation. Three major issues should be considered in interpreting the information in Table 1: differences in study methods, differences in creditor behavior, and differences in debtor attribution.

### A. *Methodological Differences in the Studies*

As demonstrated in the descriptions of the earlier studies, there have been two major ways in which researchers have studied the impact of medical issues on bankruptcy: the study of data from the peti-

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<sup>42</sup> VISA U.S.A. Inc., *supra* note 19, at 8-9.

<sup>43</sup> *Id.* at 9.

<sup>44</sup> Sullivan, Warren & Westbrook, *supra* note 1, app. 1 at 283, 330 n.5 (reporting data collected by Judge Barbara Sellers).

<sup>45</sup> Scott Fay, Erik Hurst & Michelle J. White, *The Bankruptcy Decision: Does Stigma Matter?* 22 (Jan. 1998) (unpublished manuscript, on file with the *New York University Law Review*) (noting also negative effect of stigma on decisions to file for bankruptcy). The authors added questions to the latest wave of a large panel study. The question about having filed bankruptcy was answered affirmatively by about half the respondents who would have been expected to have filed bankruptcy, based on the national filing rates. See *id.* at 17, 19. One possible reason for the underreporting might have been a higher rate of death among respondents who had filed bankruptcy—thus, the attrition from the sample might have been the result of not only the stigma attached to the filing of bankruptcy, but also of the intervening death of a potential respondent.

tions that debtors submit when they file for bankruptcy,<sup>46</sup> and direct interviews of debtors. Both methods have advantages as well as disadvantages. Analysis of petition data typically relies upon a classification of the scheduled debts to distinguish medical from nonmedical debts. For example, debts owed to physicians, hospitals, pharmacies, ambulance companies, and home health care agencies reasonably are considered medical debts. On the other hand, the debt schedules may be skewed if, for example, the debtors choose to omit their medical providers and medical debts from their bankruptcy schedules. Anecdotally, we have heard from bankruptcy lawyers that debtors may be reluctant to risk losing the services of their health care providers and thus may try to find a way to pay them even if other creditors go unpaid. Moreover, more recent data are likely to be skewed by the ubiquity of credit cards. Because most health care providers now will accept major credit cards, substantial medical debt may be subsumed into the scheduled debts to VISA or MasterCard credit card providers or may be transformed into second mortgages on homes. The loss of work-related income, another major consequence of an illness or injury, rarely can be detected from the petition data. Despite these difficulties of interpretation, however, petition data have the advantage of being filed under the penalty of perjury<sup>47</sup> and of being public data that are relatively easy to locate and to sample in a valid way.

Direct interviews of debtors, as compared with petition data, have the great advantage that the debtor can explain the reasons for the bankruptcy. But direct interviews also have disadvantages. For example, it can be difficult to classify interview data for quantitative analysis. Moreover, the responses may be hard to compare from study to study because of the questions asked, or because of the ways in which answers may be combined, but more subtle distinctions also may be made. The debtor may distinguish, for example, between the main reason for the bankruptcy and contributory reasons. Interviews present the additional difficulty of locating the debtors and, once they

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<sup>46</sup> See 11 U.S.C. § 521(1) (1994) (requiring debtors to schedule their debts).

<sup>47</sup> See 11 U.S.C. app. at 979 Official Bankruptcy Form 1 (1994) (“I declare under penalty of perjury that the information provided in this petition is true and correct.”); see also 18 U.S.C. § 152(3) (1994) (“A person who . . . knowingly and fraudulently makes a false declaration, certificate, verification, or statement under penalty or perjury . . . in or in relation to any case under title 11 . . . shall be fined not more than \$5,000, imprisoned not more than 5 years, or both.”); id. § 156(b) (stating:

If a bankruptcy case or related proceeding is dismissed because of a knowing attempt by a bankruptcy petition preparer in any manner to disregard the requirements of title 11, United States Code, or the Federal Rules of Bankruptcy Procedure, the bankruptcy petition preparer shall be fined under this title, imprisoned not more than 1 year, or both.).

have been located, getting them to complete the survey. Contrary to the view that the stigma attached to bankruptcy has declined, many researchers have encountered high refusal rates which, in turn, threaten the reliability of the study.<sup>48</sup>

The studies of medically related bankruptcies have varied in their reliance on petition data and interviews. Thus, some of the differences in findings may result from the different types of data used.

### *B. Changes in Creditor Behavior*

It is also possible that changes in creditor behavior have led to changes in the real or perceived impact of medical problems on bankruptcy. If health care providers send bills—and bill collectors—to deal with medical debt, the likelihood increases that medical problems will be foremost in a debtor's mind at the time of filing. Kovac argues that medical providers were among the creditors most likely to turn to debt collectors, who in turn pressured the debtors, who in turn sought recourse in the bankruptcy system.<sup>49</sup> In their 1981 study, Sullivan, Warren, and Westbrook found that debtors with greater medical debts were also significantly more likely to report that lawsuits had been filed against them.<sup>50</sup> Increasingly, medical service providers display a sign in their offices that proclaims: "Payment is expected at the time of service." If the providers were paid at the time services were rendered, health care expenses would press a family financially, without the family identifying these expenses as a cause of bankruptcy. As more health care providers accept credit cards, it seems likely that debtors increasingly will finance their medical care with credit. Debtors may or may not subsequently identify their credit card debt as a result of health care bills.

### *C. Changes in Debtor Attribution*

A third possible explanation for the variation in the data in earlier studies is that, over time, debtors have resorted to a more "acceptable" explanation for their bankruptcies. As medical sociologists long have argued, medical reasons are often exculpatory for actors seeking not to perform a variety of expected behaviors.<sup>51</sup> Moreover, physi-

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<sup>48</sup> For a review of the difficulties in interviewing debtors, see Sullivan, Warren & Westbrook, *supra* note 3, at 42 n.13.

<sup>49</sup> Kovac, *supra* note 16, at 710.

<sup>50</sup> Sullivan, Warren & Westbrook, *supra* note 3, at 169. It was not clear from the petition data, however, whether these lawsuits had been filed by health care providers or by some other creditor.

<sup>51</sup> See Barry Blackwell, *Sick-Role Susceptibility*, 58 *Psychotherapy & Psychosomatics* 79 (1992) (reviewing generally 526 articles on "sick role" published since 1989).

cians and other health care providers have sought to extend their authority through the "medicalization" of a number of problems.<sup>52</sup> The recent "medicalization" of smoking addictions is a good example of seeking an acceptable description for failure to take steps to stop the behavior.<sup>53</sup> Some mental health care providers now suggest that "overspending" is a medical condition and perhaps a compulsive behavior.<sup>54</sup> We have no means of determining whether debtors are seeking a more acceptable reason for their bankruptcies, and are therefore exaggerating or fabricating a medical reason. Continuing high levels of reported medical debt would seem to confirm that the medical reasons are substantial, but the changes in how health care is financed make it more difficult to make an independent assessment of the level of medical bills.

#### *D. Other Specific Findings in Prior Studies*

##### *1. Medical Insurance and Medical Debts*

A few researchers have focused on the relationship between medical insurance and bankruptcy. Based on interviews of individual bankruptcy debtors, Shuchman found that ninety-two percent of his sample reported having health insurance before the date of the bankruptcy filing.<sup>55</sup> Only 2.1% of the 1991 sample in Phase II of the Consumer Bankruptcy Project reported a specific problem with medical insurance as a reason for filing.<sup>56</sup> A more aggregated study suggests, however, that there is a correlation between insurance undercoverage and bankruptcy. Comparing bankruptcy filing rates with health insurance coverage rates at the state level, SMR Research Corporation cited medical debt as a "central problem in bankruptcy," and suggested that medical debt is a factor in more bankruptcy cases than the

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<sup>52</sup> See generally Peter Conrad & Joseph W. Schneider, *Deviance and Medicalization: From Badness to Sickness* (1992) (arguing that redefining deviant behavior as illness expands scope of work for medical professionals and prescribes treatment instead of shame for victims/patients).

<sup>53</sup> For an example of medical discussion of smoking as an addiction, see generally Timothy P. Carmody, *Preventing Relapse in the Treatment of Nicotine Addiction: Current Issues and Future Directions*, 24 *J. Psychoactive Drugs* 131 (1992).

<sup>54</sup> Cf. G.M. Schippers & W.M. Cox, *Problem Perception and Addictive Behaviors Among Dutch and American College Students*, 1 *Drugs: Educ. Prevention & Pol'y* 27 (1994) (reporting on use of survey instrument, Problem History Questionnaire, which includes overspending along with cigarette smoking, eating disorders, and addictive substance use).

<sup>55</sup> See Shuchman, *supra* note 10. In another study focusing on a group of Connecticut bankruptcy cases from 1980, Philip Shuchman and Thomas Rhorer found that sixty-eight percent had some medical debt. Philip Shuchman & Thomas L. Rhorer, *Personal Bankruptcy Data for Opt-Out Hearings and Other Purposes*, 56 *Am. Bankr. L.J.* 1, 13 (1982).

<sup>56</sup> Sullivan, Warren & Westbrook, *supra* note 1, at 145 fig.5.1.

VISA U.S.A. survey indicated.<sup>57</sup> SMR Research Corporation also noted that the bankruptcy filing rate was lower than the national average in states where at least ninety percent of the population had health insurance.<sup>58</sup>

## 2. *Demographic Differences in Medical Bankruptcy*

It is a durable finding of the studies that women are especially likely to have medically related bankruptcies. Shuchman reported that women filing singly had incurred medical expenses constituting a far larger percentage of their incomes than did men filing singly or married couples.<sup>59</sup> In an analysis of scheduled debts from 1981, Sullivan, Warren, and Westbrook also found that women filing singly had a significantly greater ratio of medical debt to income than did joint filers or men filing singly.<sup>60</sup> The 1991 study found the age differences in medical bankruptcies that might be expected, but medical bankruptcies did not differ significantly by region of the country or by racial/ethnic group.<sup>61</sup> The varying results may be attributable to different approaches to gathering the data over different time periods, but the data point toward the growing use of bankruptcy to deal with the financial aftermath of a health-related problem.

## II

### CALCULATING MEDICALLY RELATED BANKRUPTCIES: THE 1999 DATA

#### A. *Methodology and General Findings*

To gain additional information on medically related bankruptcy in light of the various results previously reported, our survey included several questions designed to approach medically related bankruptcies from multiple perspectives. First, we asked a representative of each family to identify the family's reasons for filing bankruptcy.<sup>62</sup> The questionnaire gave him or her a choice of sixteen possible reasons, including the all-encompassing "something else" with additional blank lines so that the debtors could provide supplemental information.<sup>63</sup>

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<sup>57</sup> SMR Research Corp., *The Personal Bankruptcy Crisis, 1997: Demographics, Causes, Implications & Solutions* 94-95 (1997).

<sup>58</sup> *Id.* at 97.

<sup>59</sup> Sullivan, Warren & Westbrook, *supra* note 3, at 289.

<sup>60</sup> *Id.* at 171.

<sup>61</sup> Sullivan, Warren & Westbrook, *supra* note 1, at 163-64.

<sup>62</sup> See *infra* app. 2 at question 13.

<sup>63</sup> Question 13 stated: "People give many reasons for filing bankruptcy. Please check all of those that apply to you." See *id.* . We included every reason that appeared more than a few times in response to the 1991 survey from Phase II of the Consumer Bankruptcy

One of the sixteen specific options, "illness or injury of self or family member," identified a medical reason for filing. The questionnaire did not ask families to rank their reasons. One in every four families in the sample (25.2%) identified an illness or injury as a reason for filing bankruptcy. If the families in the sample are representative of families around the country, an estimated 324,268 bankrupt families in 1999 would have identified a medical reason for their bankruptcy filings.

In addition to asking families why they filed for bankruptcy, we also asked two questions relating specifically to medical bills and debts. By doing so, we thought we might draw additional inferences about medical debt contributing to a family's financial collapse.<sup>64</sup> The questionnaire posed the following question: "Most filers in bankruptcy have a number of creditors. Do you owe money to any of these types of creditors? (Check all that apply)."<sup>65</sup> One of the fourteen options was "Health Care Providers, Services, Supplies."<sup>66</sup> There was no minimum or maximum dollar amount for this question. About a third (31.2%) of the families, or an estimated 401,475 families in 1999, reported that they had this type of outstanding bill. Among those who listed an unpaid medical bill for health care providers, services, and supplies, more than half (63.4%) did not identify a medical reason for filing bankruptcy. Even if these debtors did not perceive that medical problems contributed to their financial collapse, health care providers are nonetheless creditors in these bankruptcy cases, making it likely that they would receive little more than a few cents on the dollar, if

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Project, plus others that had been suggested to us (e.g., gambling). The sixteen reasons were: "Job Problems," "Illness or Injury of Self or Family Members," "Divorce or Family Breakup," "Addition of a Family Member," "Victim of Fraud or Crime," "May Lose Home (eviction, foreclosure)," "Gambling," "Trouble in Managing Money," "Employer's Business Failed," "Car Accident," "Death of a Family Member," "Credit Card Debt Out of Control," "Victim of a Disaster (for example, flood)," "Aggressive Collection Efforts by Creditor," "Alcoholism or Drug Addiction," and "Something Else (what?)." *Id.* The questionnaire permitted the respondents to supply as many reasons as they believed applicable, see *id.*, in recognition of the fact that several types of problems might contribute to financial collapse. In Phase II of the Consumer Bankruptcy Project, the questionnaire provided no explicit options and instead asked the debtors an open-ended question about why they filed. See Sullivan, Warren & Westbrook, *supra* note 1, at 269.

<sup>64</sup> Asking separately about medical bills also gave us more information on how many medical bills and medical providers go unpaid as a result of bankruptcy. Bankruptcy losses could contribute, at least in some measure, to rising health care costs for other consumers. Whether or not the obligation to contain costs lies at the feet of medical providers themselves, they nonetheless face the repercussions when their bills go unpaid.

<sup>65</sup> *Infra* app. 2 at question 11.

<sup>66</sup> *Id.*

anything, for their outstanding bills.<sup>67</sup> These data suggest that medical debt remains widespread in bankruptcy in the days of third-party payment and widespread use of credit cards, even among those for whom it is not a principal cause of filing.<sup>68</sup>

The ubiquity of medical debt is more complicated, however, than this finding suggests. More than half (54.9%) of the debtors who gave a medical reason for filing did not also say that they owed medical bills directly to providers. Notwithstanding their claim that they filed at least in part because of a health-related problem, they owed no specific medical bills at the time they filed. There are a number of possible explanations for this outcome. Some debtors who file for bankruptcy in the wake of an illness or injury may have bankrupted themselves by paying their medical debts. They may have no remaining medical debts, but they cannot pay their other creditors. Other debtors may have listed a medical reason for filing because they lost their jobs due to injury or illness, even though their health insurance picked up the tab for the medical bills themselves. Still others may have listed a medical reason for filing and still may owe thousands of dollars for goods and services from health care providers, although they used a credit card to pay the hospital, the doctor, and the pharmacy. Thus, they owe a large debt to their credit card company on account of their medical problems, but owe nothing to health providers directly.<sup>69</sup> For debtors with particularly large medical bills, it may be the case that medical bills are now in the form of a second, third, or fourth home mortgage, and thus are not owed directly to the health provider. As noted earlier, this is one of the reasons why the existence of medical debts cannot be determined with any accuracy from

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<sup>67</sup> As previously noted, some debtors might refrain from listing medical debts on their bankruptcy schedules, fearing that necessary medical care will be discontinued. In such cases, health care providers would remain legally entitled to 100 cents on the dollar. See 11 U.S.C. § 523(a)(3) (1994) (excepting from discharge unlisted and unsecured debts under some circumstances).

<sup>68</sup> We cannot identify from this question whether the provider or creditors who might have gone unpaid were large institutions or family pharmacies. Because this question did not provide a minimum or maximum dollar value, we also cannot estimate from these data how much medical debt owed directly to providers was discharged. Even if we knew how much medical debt was carried into bankruptcy by debtors, we could not assume that it was all discharged, because many debtors agree to remain liable for some of their debts after bankruptcy. See *id.* § 524(c), (d) (authorizing reaffirmation of otherwise dischargeable debt under some circumstances); see also Marianne B. Culhane & Michaela M. White, *Debt After Discharge: An Empirical Study of Reaffirmation*, 73 *Am. Bankr. L.J.* 709, 709-13 (1999) (reporting results of study on how many debtors remain legally liable for otherwise dischargeable debts after bankruptcy due to reaffirmation agreements).

<sup>69</sup> See Sullivan, Warren & Westbrook, *supra* note 1, at 152-55 (discussing reasons why discovery of medical debt as cause of bankruptcy may be indefinable).

the petition and schedules that debtors file with the bankruptcy courts.<sup>70</sup>

To identify debtors with *substantial* medical debts, we asked an additional question about medical bills: whether the debtor had medical bills not covered by insurance in excess of \$1000 during the past two years.<sup>71</sup> Because this question was not limited to debt owed directly to health providers, but was focused instead on the origin of the obligation, it included debt paid prior to bankruptcy, credit card debt, or a second mortgage, if the obligation was incurred for medical treatment. Although \$1000 (which is the minimum for the question—there was no maximum) is not a magic number in any sense, it is a substantial sum for the debtors in our sample, who had a median gross income of about \$28,000. Thus, the minimum bill to trigger this question amounted to a little more than 3.5% of the family's total annual gross income.

Identifying debtors with substantial medical debt is more pertinent than identifying outstanding medical bills at the time of filing for individual families that truly have struggled with health care costs. If the debts are large enough, they might have contributed to the debtors' financial problems, even if the debtors themselves did not identify health problems as contributing to their ultimate financial downfall.<sup>72</sup> One-third (33.8%) of the debtors, or an estimated 434,931 families in 1999, reported that they had substantial medical debt.<sup>73</sup>

It is possible to combine the responses to identify those who gave either or both of two responses, without counting anyone twice. The data show that nearly half (46.2%) of the bankruptcy sample identified either that they filed for a medical reason or that they had incurred a minimum of \$1000 in health-related bills.<sup>74</sup> Combining those identifying illness or injury as a cause of bankruptcy with those indi-

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<sup>70</sup> The use of consumer debt to pay medical costs is not an entirely new phenomenon. See *id.* at 146 (discussing 1970s survey reporting "that the number-one reason for taking out personal loans other than for durable goods was to pay medical costs"). Of course, this identification problem is not limited to medical debts. Other types of debts, such as taxes, are equally unidentifiable in the bankruptcy files when the original creditor's debt has been satisfied with a credit card or other third-party payment. All that shows up in the files, in such an instance, is the credit card debt. This also means that large credit card debts in the bankruptcy files sometimes can be explained by something other than irresponsible purchases.

<sup>71</sup> See *infra* app. 2 at question 6a.

<sup>72</sup> Because the question includes debts owed to medical providers that were satisfied prior to filing (either by the debtor or by a third-party payor), it also does not help to determine the extent to which health providers go unpaid as a result of bankruptcy.

<sup>73</sup> See *infra* fig.1.

<sup>74</sup> Of the 46.2% who answered yes to one or both questions, the breakdown was as follows: 20.2% said they had substantial medical bills, 11.8% identified a medical cause, and 13.7% identified both substantial medical bills and said they had a medical cause.



cating substantial medical bills (an overlapping but not perfectly coextensive group) this proportion extrapolates to 594,491 families filing for bankruptcy in 1999 with a medical cause implicated.<sup>75</sup>

Some of the other reasons for filing that we listed as options on the questionnaire may have a medical component, and thus the proportion of debtors identifying a medical reason would increase if we included in our count those who identified reasons such as childbirth or the death of family members. The birth of a baby may result in medical bills that a family cannot manage, as well as other financial pressures (e.g., one parent quitting a job or the family moving to larger housing). Similarly, a constellation of both medical and non-medical financial pressures may accompany the death of a spouse: The survivor might be left with medical bills, but also may have substantially less income to meet ongoing expenses. About 6.6% of the debtors listed "addition of a family member" as a reason for filing, and approximately 4.4% listed "death of a family member."

We cannot be sure whether these reasons do, in fact, include a medical component in any particular case, but these considerations serve as a reminder that medical problems are not always extracted easily from other interrelated circumstances. Adding people who identified birth of a baby and death in the family to those identifying medical reasons specifically makes the data more comparable to that of the Brookings Report from the 1970s.<sup>76</sup> In 1999, the proportion of families listing health care problems, birth of a baby, death in the family, or substantial medical bills would have risen to half (50.0%) of all the consumer bankruptcy filings in the United States. This would put the extrapolated national estimate of affected debtors at 643,389.<sup>77</sup> The different ways of identifying a medical problem are summarized in Figure 1. If similar fractions of bankruptcies involved medical problems throughout the 1990s, there would have been approximately

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<sup>75</sup> Disaggregating the most frequently identified reasons by filing status and combining both an identified medical reason and a substantial medical debt in the "medical" category, the financial consequences of medical problems are a close second for married couples and a close third for women filing singly. Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Medical Problems and Bankruptcy Filings*, Norton Bankr. L. Adviser, May 2000, at 1, 3 fig.1. Medical problems were listed fourth most frequently by men filing singly, behind job problems, credit cards, and money management. *Id.*

<sup>76</sup> See Stanley & Girth, *supra* note 7.

<sup>77</sup> This counts everyone who gave at least one of the listed responses, but counts no one twice. The data show that about 32.2% of all the bankrupt debtors gave one of the four listed reasons, while another 15.6% gave two listed reasons. Another 2.1% listed three, and 0.1% listed all four.

five million medically related bankruptcies this decade (i.e., 50% of 10.7 million filings).<sup>78</sup>

### B. *Filing Status: Men, Women, and Married Couples*

Medically related filings vary by filing status. Nearly one-third of married couples (thirty-one percent) reported a medically related filing in 1999. For women filing singly, more than a quarter (twenty-six percent) had a medically related bankruptcy. For men filing singly, eighteen percent reported a medically related filing.<sup>79</sup> These relative proportions are summarized in Figure 2.

The *number* of women filing singly and giving a medical reason is nearly double the number of men filing singly and giving a medical reason.<sup>80</sup> The reason for this discrepancy, which is larger than the difference in proportions indicated in Figure 2, is that the percentage of women filing singly, as a share of all bankruptcies, is growing rapidly.<sup>81</sup> During the 1990s, when bankruptcy filings increased substan-

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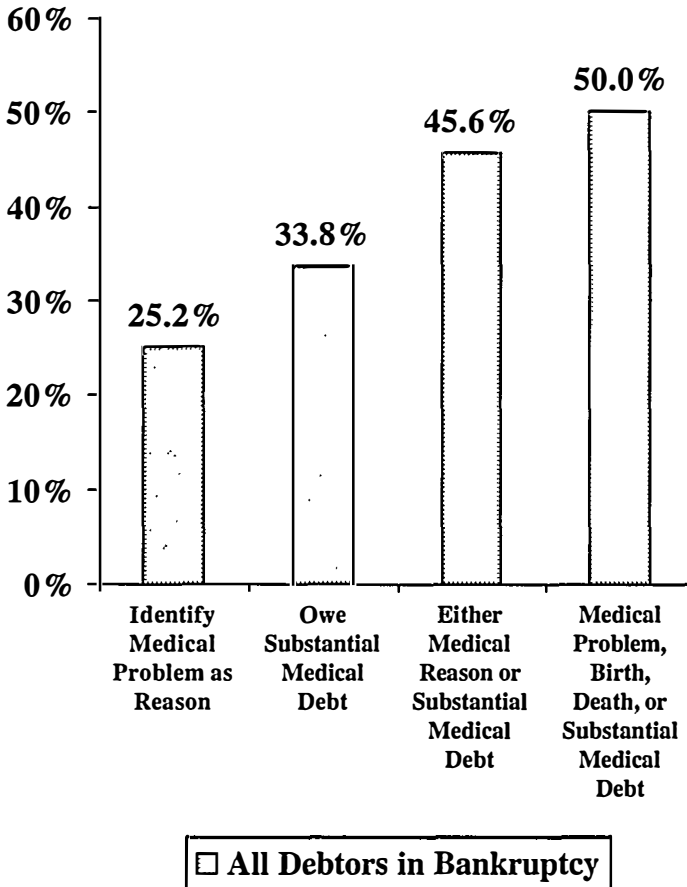
<sup>78</sup> See News Release, Admin. Office of the U.S. Courts, Bankruptcy Filings Down in Calendar Year 2000 (Feb. 23, 2001) (listing number of filings from 1996 to 2000), [http://www.uscourts.gov/Press\\_Releases/press\\_02232001.pdf](http://www.uscourts.gov/Press_Releases/press_02232001.pdf); News Release, Admin. Office of the U.S. Courts, Bankruptcy Filings Show Sharp Increase in 1995 (Mar. 1, 1996) (listing number of filings from 1991 to 1996), [http://www.uscourts.gov/Press\\_Releases/12bank.htm](http://www.uscourts.gov/Press_Releases/12bank.htm). Debt and medical problems may be aligned differently for some Americans from the way that we document them here. It may be the case that the stress of large bills takes a toll on one's health. A recent survey suggests that a high credit card balance was one of the best predictors of physical problems, even after accounting for age, educational level, and job status. Attempting to link these results with ours, one could speculate that financial distress may serve to exacerbate the problems of those in medically related bankruptcies. See Patricia Drentea & Paul J. Lavrakas, *Over the Limit: The Association Among Health, Race and Debt*, 50 Soc. Sci. & Med. 517, 527 (2000) (linking debt stress and health based on results of telephone study).

<sup>79</sup> In 1991, there were no reported differences in medical reasons by gender or filing status. Sullivan, Warren & Westbrook, *supra* note 1, at 164 ("Without a systematic question about the debtor's medical debts, we cannot be sure whether single women are carrying relatively similar medical burdens as single men and married couples or whether they are describing their problems somewhat differently.").

<sup>80</sup> See *infra* fig.3.

<sup>81</sup> See Teresa Sullivan & Elizabeth Warren, *The Changing Demographics of Bankruptcy*, Norton Bankr. L. Adviser, Oct. 1999, at 1, 1. Couples filing together come in a close second, and men filing singly constitute the smallest group. *Id.* at 2 tbl.1. Using the latest filing figures for 1999, see Leonidas Ralph Mecham, Admin. Office of the U.S. Courts, *Judicial Business of the United States Courts: 1999 Annual Report of the Director* 268 tbl.F (2000) (listing number of bankruptcy cases commenced, terminated, and pending during twelve-month periods ending September 30, 1998 and 1999), <http://www.uscourts.gov/judbus1999/f00sep99.pdf>, an estimated 496,824 women filing singly filed for bankruptcy, along with 423,479 couples and 366,603 men filing singly. These numbers differ somewhat from the estimated numbers in Sullivan & Warren, *supra*, which were based on estimations from the second half of 1998 and first half of 1999, because the total number of bankruptcy filings continued to decline during the second half of 1999.

FIGURE 1: MEDICAL DEBT AND BANKRUPTCY, 1999



Note: Reasons may overlap.

Source: Consumer Bankruptcy Project: Phase III (1999).

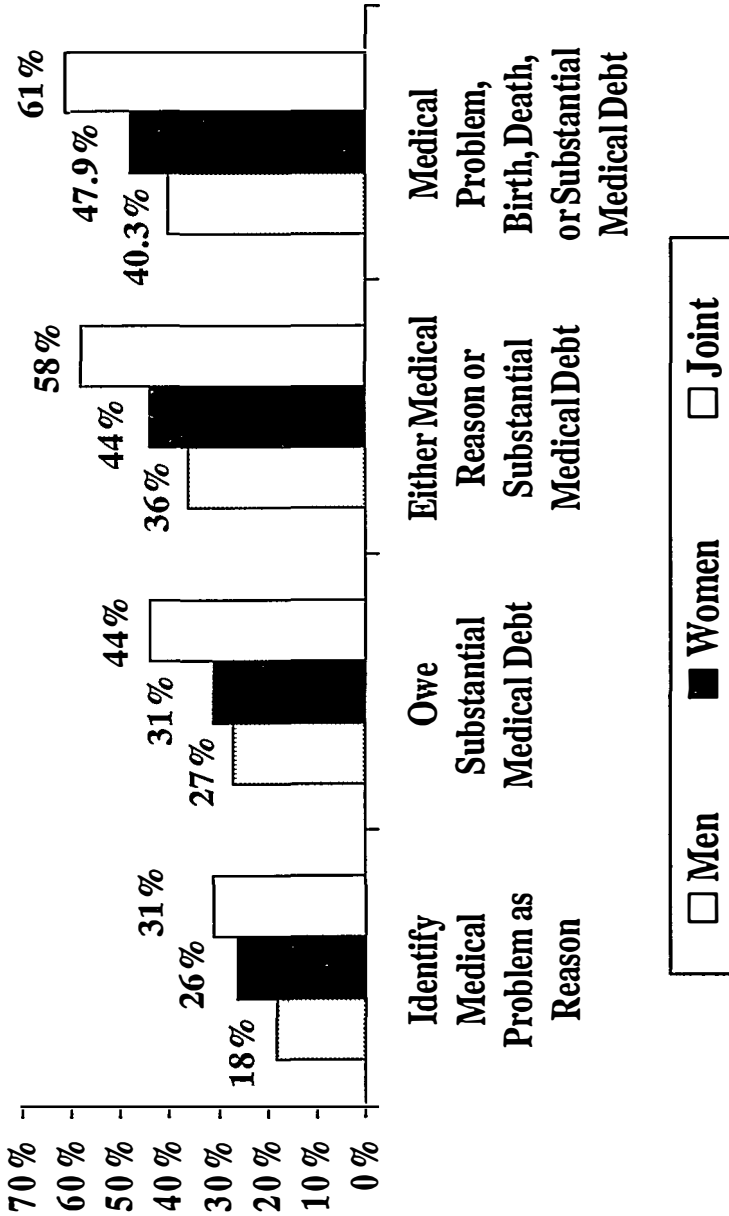
tially,<sup>82</sup> the percentage of women filing singly also enlarged, with the result that there were many more women in bankruptcy by 1999.<sup>83</sup> Figure 3 provides the estimated number of medically related bankruptcies filed in 1999 by filing status.

The *relative* risk of a medically related bankruptcy is, however, even greater for women than these figures suggest. Female-headed households are much less numerous in the population than they are in

<sup>82</sup> See supra note 78 and accompanying text.

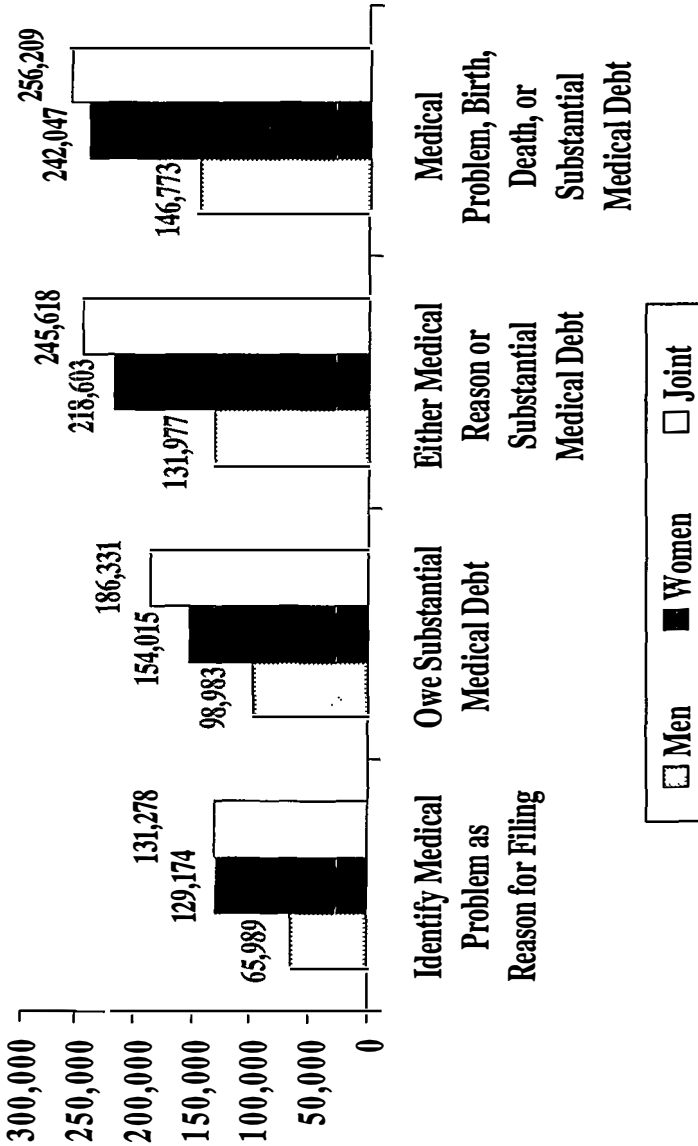
<sup>83</sup> See supra note 81 (providing number of increased filings by women). An increasing percentage of petitioners who are women filing singly, combined with a rising number of cases, results in an increased number of women in bankruptcy.

FIGURE 2: MEDICAL DEBT AND BANKRUPTCY, BY FILING STATUS, 1999



Note: Reasons may overlap.  
 Source: Consumer Bankruptcy Project: Phase III (1999).

FIGURE 3: REASONS GIVEN FOR CONSUMER BANKRUPTCY EXTRAPOLATED TO NATIONAL BANKRUPTCY FILING, BY FILING STATUS, 1999



Note: Numbers do not add to total filings because debtors gave multiple responses.  
 Source: Consumer Bankruptcy Project: Phase III (1999); U.S. Census Bureau, Current Population Reports, No. P60-206, Money Income in the United States 1 tb1.1 (1998) (listing 1998 household composition data).

the bankruptcy courts.<sup>84</sup> Conversely, married couples are more common in the general public than they are in the bankruptcy courts, where they comprise more than half of all households.<sup>85</sup> In order to correct for both the relative risk and the relative numbers of the household types, it is helpful to calculate a medically related bankruptcy filing rate per 10,000 households.

Table 2 presents filing rates for medical reasons for four comparisons. The highest filing rate, 42 per 10,000, is for women in a household with no adult male present. This rate is 12 per 10,000 higher than the 30 per 10,000 for households with an adult woman present (whether or not there are males present).<sup>86</sup>

The 12 per 10,000 difference can be decomposed into a difference of 15 per 10,000 due to the “protective effect” of having an adult male in the household (42 per 10,000 without a man present versus 27 per 10,000 with a man present). There is a much smaller “protective effect” of having a woman present, 36 per 10,000 for households without a woman versus 30 per 10,000 for households with a woman present. These two differences ( $15 + 6 = 21$ ) overdetermine the total difference in rates. The correction factor—adult man present regardless of women versus households of males only—shows that the presence of married women normally would increase the bankruptcy filing rate by 9 per 10,000.<sup>87</sup> This leads to the decomposition: 15 (protective effect of males) + 6 (protective effect of females) - 9 (correction for marriage) = 12.

If we use a different measure of medically related bankruptcies, the gap remains, although its size changes slightly. For example, households without a male present reporting a substantial medical debt have a filing rate of 50 per 10,000, versus a rate of 39 per 10,000 for households with a man present. This is a gap of 11 filings per

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<sup>84</sup> Of the 103,874,000 families in the United States in 1998, 54,770,000 were married couples; 12,789,000 were women with related family members and no husband; 17,971,000 were women living alone or with unrelated persons; 3,976,000 were men with related family members and no wife; 14,368,000 were men living alone or with unrelated persons. U.S. Census Bureau, Current Population Reports, No. P60-206, Money Income in the United States, at vi tbl.A (1998), <http://www.census.gov/prod/99pubs/p60-206.pdf>.

<sup>85</sup> See *id.*

<sup>86</sup> It is possible for a male filing singly in bankruptcy to live in a household with an adult woman, and it is possible for a woman filing singly to live in a household with an adult male. Empirically, however, these configurations are rare among the bankruptcy filers in our sample.

<sup>87</sup> Another way to conceptualize the correction for marriage is to say that the married couple does not receive the additive effects of having an adult male plus an adult female. Instead, there is an interaction effect such that the total is less than the sum for men and women.

TABLE 2: MEDICALLY RELATED BANKRUPTCIES<sup>a</sup> PER 10,000 HOUSEHOLDS UNDER VARYING GENDER COMPOSITIONS, 1999

Adult Woman	Adult Woman
Present <sup>b</sup>	Absent
30	36
Adult Man	Adult Man
Present <sup>c</sup>	Absent
27	42

Decomposition:

Total difference in rates due to gender composition: $(42-30) = 12$
Protective effect of adult male to female household: $(42-27) = 15$
Protective effect of adult female to male household: $(36-30) = 6$
Corrective effect for marriage: $(27-36) = -9$

Source: U.S. Census Bureau, Consumer Bankruptcy Project Phase III (1999).

Notes:

<sup>a</sup> Based on giving a medically related reason for the bankruptcy.

<sup>b</sup> All households with a woman present, either as wife or householder.

<sup>c</sup> All households with a man present, either as husband or householder.

10,000, a little smaller than the gap that results from using a medical reason alone.

If medically related bankruptcy is defined by medical debt or a medical reason, the largest gap results: 19 per 10,000. This is the gap between 71 per 10,000 for households without a male present versus 52 per 10,000 for households with a male present.

What is the protective effect of males in a household? Perhaps because of their higher incomes or because their jobs offer better insurance, men are insulated better than are women from filing bankruptcy for medical reasons. The presence of an adult woman has a much smaller protective effect. The protective effect added by the presence of a woman simply may be the addition of a second income and a second chance at medical insurance, rather than the better incomes and better medical insurance that men often have.

Another way to frame the issue is to ask about the source of the greater vulnerability of women. It is a long-standing generalization that women are more likely to be ill than men, although men have a higher mortality rate.<sup>88</sup> In addition, women in child-bearing years have added medical costs for reproductive services. Women earn less

<sup>88</sup> John R. Weeks, *Population: An Introduction to Concepts and Issues* 176-77 (5th ed. 1992); see also U.S. Census Bureau, *Statistical Abstract of the United States* 134 tbl.199 (1999) (women average 3.5 visits to physicians per year, versus 2.4 for men).

and may be less likely to have insurance, which reduces their resources when medical costs are incurred.<sup>89</sup> A far greater issue, however, is that female-headed households are far more likely than male-headed households to have dependent children who also need health care.<sup>90</sup> At a minimum, children must receive vaccinations to enroll in school, and many schools require an annual doctor's verification of a child's health. In any event, gender and household structure appear to be important correlates of medically related bankruptcies.

### C. *Medical Debts and Older Americans*

The data also demonstrate considerable differences among various age groups in identifying illness or injury as a reason for filing, with the elderly most at risk. The differences are illustrated in Figure 4.<sup>91</sup>

The youngest debtors in bankruptcy were least likely to indicate that their financial problems stemmed from a medical problem.<sup>92</sup> Only 7.2% of debtors under the age of twenty-five identified a medical reason for filing. Medical problems continue to increase through the peak earning years. The proportion of debtors between twenty-five and sixty-four who listed medical reasons ranged from twenty-one percent to thirty-three percent.

These data show that the oldest debtors constitute the group that most often identifies a medical reason for filing for bankruptcy.<sup>93</sup> Notwithstanding Medicare and some retirement benefits, nearly half (46.7%) of the debtors sixty-five and older specifically identified ill-

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<sup>89</sup> U.S. Census Bureau, *supra* note 88, at 475 tbl.744 (reporting that female-headed households with husband absent have median income of \$23,040, versus \$51,631 for households of married couples and \$36,634 for male-headed households with no wife); see also *id.* at 482 tbl.758 (reporting that full-time, year-round female workers average earnings of \$29,261 versus \$43,709 for similarly situated male workers).

<sup>90</sup> *Id.* at 67 tbl.83 (noting that in 1998, sixty-eight percent of children under eighteen lived with both parents, twenty-three percent lived with mother only, four percent lived with father only, and four percent lived with neither parent); see also *id.* at 66 tbl.81 (noting that of all female-headed households in 1998, sixty-one percent had dependent children, versus forty-six percent of male-headed households and forty-seven percent of households of married couples).

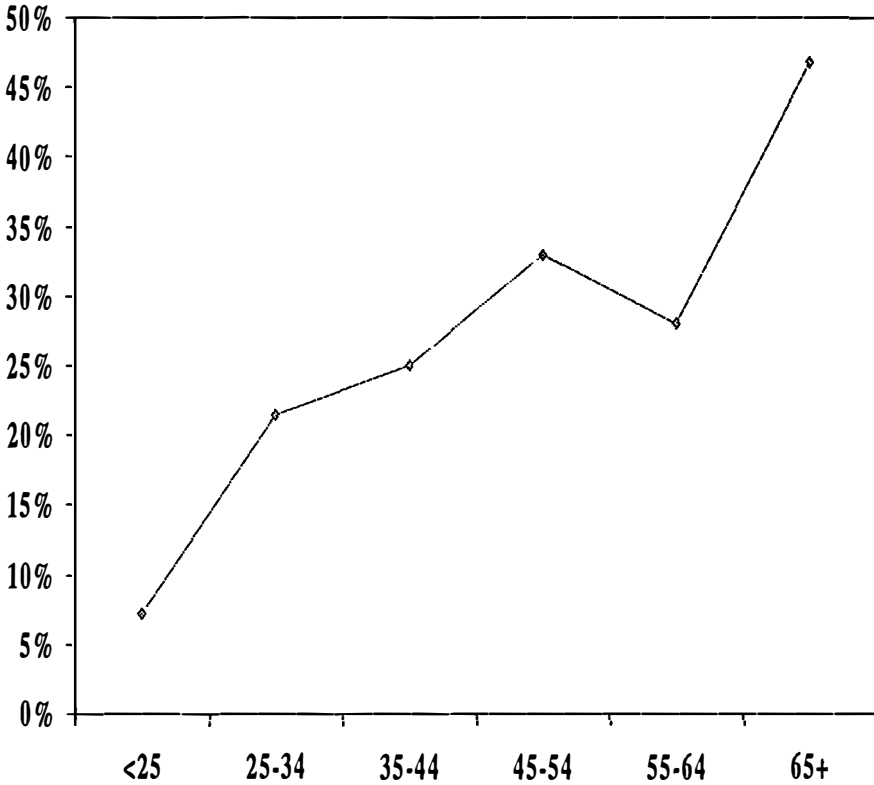
<sup>91</sup> Figure 4 accounts only for debtors identifying medical reasons for their bankruptcies, not those identifying substantial medical debts, although the overall pattern would remain similar if we combined those listing either medical reasons or substantial medical debt.

<sup>92</sup> But cf. Allison Stein Wellner, *The Young & the Uninsured*, *Am. Demographics*, Feb. 1999, at 72, 74 (reporting that young adults are most likely to suffer from certain acute conditions, especially injuries, such as traumatic brain injuries).

<sup>93</sup> We found no significant difference among different racial groups in their reports of medical reasons for their bankruptcy. Again, this finding is consistent with the 1991 data reported in Sullivan, Warren & Westbrook, *supra* note 1, at 163.



FIGURE 4: MEDICAL REASON FOR BANKRUPTCY FILING, BY AGE GROUP, 1999



Note: Medical reason only, not including medical debt.

Source: Consumer Bankruptcy Project: Phase III (1999).

ness or injury as a reason for their bankruptcy filings.<sup>94</sup> These data demonstrate the special vulnerability of the elderly to serious financial reversals associated with health care.<sup>95</sup> The results are particularly relevant to questions regarding health care in light of estimates that the share of our population over sixty-five is expected nearly to double and that the share of the population over eighty-five is expected to more than triple by 2050.<sup>96</sup> We explore health-related bank-

<sup>94</sup> See *supra* fig.4.

<sup>95</sup> For further information on the older Americans in bankruptcy from Phase II of the Consumer Bankruptcy Project, see generally Teresa A. Sullivan, Elizabeth Warren & Jay Lawrence Westbrook, *From Golden Years to Bankrupt Years*, Norton Bankr. L. Adviser, July 1998, at 1.

<sup>96</sup> David M. Cutler & Louise Sheiner, *Demographics and Medical Care Spending: Standard and Non-Standard Effects 1* (Fed. Reserve Bd., Finance and Economics Discussion Series No. 1999-20, 1999), <http://www.federalreserve.gov/pubs/feds/1999/199920/199920pap.pdf>.

ruptcies of the elderly in greater detail in connection with a consideration of the effects of health care coverage.

#### *D. The Role of Insurance*

Barely a day goes by without a media story on health care. In these stories, medical insurance often plays the starring role.<sup>97</sup> Whether insurance is a moral hazard or a moral opportunity,<sup>98</sup> uninsured families (at least those who also lack ample private wealth), perpetually teeter on the brink of a medically related financial crisis. Our results suggest that many families with health insurance are in similarly precarious positions. The data demonstrate that having a basic health insurance policy does not necessarily protect these families from being crushed by the financial consequences of an illness or accident.

To give the broadest sweep in the effort to identify insurance, the questionnaire asked whether the debtor(s) had any form of health insurance.<sup>99</sup> One in five (20.9%) families in bankruptcy, or an estimated 268,937 families, had no health insurance. Men filing singly had the lowest insurance rate, married couples had the highest rate, and women filing singly fell in between. This is a particularly interesting division, given these groups' respective identification of medical

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<sup>97</sup> See, e.g., Robin Toner, *Bush's Approach to the Uninsured May Be Vulnerable in Its Details*, N.Y. Times, Apr. 24, 2000, at A1 (analyzing George W. Bush's proposed health care plan and its treatment of uninsured).

<sup>98</sup> See Robert J. Blendon & Karen Donelan, *Public Opinion and Efforts to Reform the U.S. Health Care System: Confronting Issues of Cost-Containment and Access to Care*, 3 Stan. L. & Pol'y Rev. 146, 147 (1991) (describing general view of leading economists that individuals overconsume health services as result of comprehensive policies, and contrasting that view with perception of American public, which is far from believing people are overinsured); Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. Health Pol. Pol'y & L. 931, 931 (1999) (explaining how traditional fee-for-service model of health insurance left providers largely unaccountable for cost of care); Louis Kaplow, *The Income Tax as Insurance: The Casualty Loss and Medical Expense Deductions and the Exclusion of Medical Insurance Premiums*, 79 Cal. L. Rev. 1485, 1487 (1991) (arguing that second-level insurance implicit in medical expense tax deduction has undesirable effects on consumption and insurance decisions, encouraging individuals to purchase less insurance because of opportunity for free partial insurance through tax rules); Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 Conn. Ins. L.J. 11, 15 (1999-2000) (arguing that health insurance stimulates development of harm-alleviating technologies and occupations that then become part of societal standard of care). See generally Kevin P. Quinn, *Viewing Health Care as a Common Good: Looking Beyond Political Liberalism*, 73 S. Cal. L. Rev. 277 (2000) (reconceptualizing justification for improving health care finance system).

<sup>99</sup> See *infra* app. 2 at question 6. We did not ask debtors about the source of the coverage and thus do not have information on government plans, private employers, or individual insurance obtained through the private market.

problems.<sup>100</sup> In light of the considerable numbers of families lacking health insurance in the United States,<sup>101</sup> including those who would be considered middle class,<sup>102</sup> it is not surprising that uninsured families turn up in the bankruptcy system.

What surprised us, however, is that there was no clear association between identifying a medical problem and being uninsured. That is, those who had insurance were about equally distributed among those who identified a medical problem and those who did not. Conversely, many debtors lacking insurance did not list a medical reason or a substantial medical debt. It may not be so surprising that some people who face financial problems happen not to have health insurance; after all, if a family cannot afford to acquire health insurance and is not obtaining it from an employer or the government, the family is likely to be having trouble satisfying other obligations. Thus, people lacking health insurance, whether or not they face a catastrophic illness or

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<sup>100</sup> The differences among the groups were significant at  $p < 0.001$ . The standard deviation is a basic statistic that measures how far from the mean a given observation lies. See George W. Snedecor & William G. Cochran, *Statistical Methods* 49-51 (7th ed. 1980). Accordingly, this statistical test indicates that a difference as large as the one we found is unlikely to have occurred by chance.

<sup>101</sup> The U.S. Census Bureau reported in September 2000 that 15.5% of the population was without health insurance coverage during the entire 1999 calendar year, down approximately 1.7 million people from the previous year, the first decline since 1987, when comparable health insurance statistics were first available. Robert J. Mills, *Health Insurance Coverage 1* (U.S. Census Bureau, Current Population Reports No. P60-211, 2000), <http://www.census.gov/prod/2000pubs/p60-211.pdf>. Based on data from the 1993 Survey of Income and Program Participation, the Census Bureau reported that about twenty-nine percent of the population (71.5 million people) lacked health insurance for at least one month in a thirty-six month period beginning in early 1993. Robert L. Bennefield, *Who Loses Coverage and for How Long? 1* (U.S. Census Bureau, Current Population Reports No. P70-64, 2000), <http://www.census.gov/prod/3/98pubs/p70-64.pdf>.

<sup>102</sup> See, e.g., Kenneth E. Thorpe, *Nat'l Coalition on Health Care, The Rising Number of Uninsured Workers: An Approaching Crisis in Health Care Financing* (1997) ("Middle income families with children, earning between \$20,000 and \$60,000 were more likely to lack health insurance in 1995 than in 1990."), <http://www.nchc.org/1998PolicyStudies/TheRisingNumberofUninsured.html>; Enthoven & Singer, *supra* note 98, at 932 (noting that rising health care costs are pricing health insurance out of reach of people with moderate means); see also Mollyann Brodie & Robert J. Blendon, *The Public's Contribution to Congressional Gridlock on Health Care Reform*, 20 *J. Health Pol. Pol'y & L.* 403, 404 (1995) ("The growing number of uninsured, benefit cutbacks, shifting cost-sharing arrangements, and increasing health care costs left middle-class Americans worried about their ability to afford needed health care services and fearful that a serious illness would devastate their finances."). Families' lack of health insurance may not be for lack of access. To the contrary, there is some evidence that the number of workers offered insurance from employers has grown, with the insurance rate decline attributable to changes in the proportion of workers who accept coverage. See Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, *Health Aff.*, Nov./Dec. 1997, at 142, 144; see also Wellner, *supra* note 92, at 74 (explaining why Generation Y is "saying no to health insurance," with price topping list of reasons).

injury, may be likely to seek bankruptcy when confronted with whatever constellation of financial pressures that prevented them from having obtained coverage.<sup>103</sup> Those lacking health insurance also may forgo needed medical care, leading to more significant—and expensive—health problems that could have been thwarted by preventive medicine.<sup>104</sup>

By contrast, nearly eighty percent of the bankrupt families had at least some health insurance coverage at the time of their bankruptcy filings. Contrary to what one might anticipate, the results reported in Figure 5 suggest that higher rates of insurance were coupled with higher rates of medically related financial problems.

Married couples reported the highest rate of health insurance (84.1%),<sup>105</sup> but they also were more likely than men filing singly to provide a medical reason for their bankruptcy filing, to have incurred substantial medical debt, or to list either a medical reason or a substantial medical debt.<sup>106</sup> Conversely, men filing singly were proportionately more likely to lack health insurance,<sup>107</sup> but were less likely to list a medical reason for filing or to have a substantial medical bill at the time of filing.<sup>108</sup> Women filing singly were somewhere in the middle.<sup>109</sup>

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<sup>103</sup> This supposition is supported by a 1995 Census Bureau study of whether American families were able to meet basic needs. See Kurt J. Bauman, *Extended Measures of Well-Being: Meeting Basic Needs 5* (U.S. Census Bureau, Current Population Reports No. P70-67, 1999), <http://www.census.gov/prod/99pubs/p70-67.pdf>. The Census Bureau found that “[p]eople who were without health insurance for at least 1 of the 4 months prior to the interview were more than twice as likely to live in a household with any difficulty meeting basic needs as those who had continuous coverage,” leading the author of the report to conclude that pressing needs may prevent the uninsured from obtaining health insurance. *Id.*

<sup>104</sup> Kurt Bauman’s study found that the lack of health insurance strongly affected the probability that there would be a person in the household who needed, but failed to seek, medical attention: “While only 3.1% of the insured population lived in a household where needed medical care was not obtained, 14.9% of those without health insurance faced this situation.” *Id.* at 5.

<sup>105</sup> See *supra* fig.5.

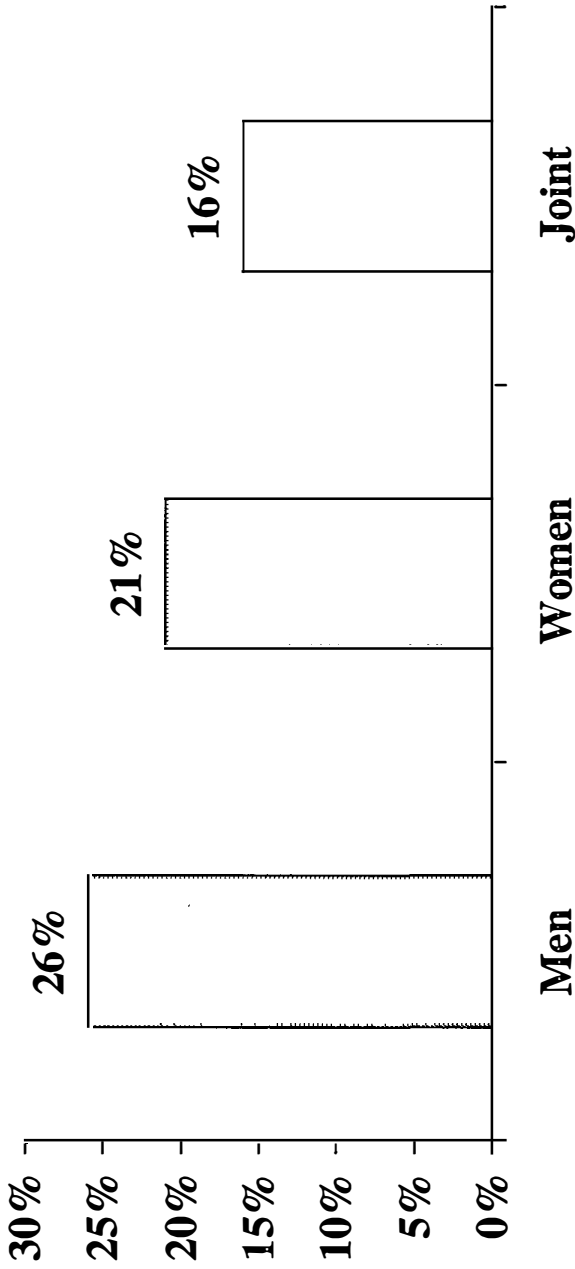
<sup>106</sup> See *supra* fig.2.

<sup>107</sup> See *supra* fig.5.

<sup>108</sup> See *supra* fig.2.

<sup>109</sup> Based on data from the 1993 Survey of Income and Program Participation, the Census Bureau reported that women were less likely than men to lack continuous health coverage. The Bureau offered two explanations for this phenomenon: First, women were more likely to live in families with incomes below the poverty line, and second, more women than men are aged sixty-five years and over. The report concluded that both reasons indicated that women instead were covered by Medicare. Bennfield, *supra* note 101, at 2-3. For additional research on different insurance rates for men and women, see Louise Sheiner, *Health Care Costs, Wages, and Aging 17-21* (Fed. Reserve Bd., Finance and Economics Discussion Series No. 1999-19, 1999) (explaining wage/age inclines in employer-paid health insurance coverage for both males and females), <http://>

FIGURE 5: PROPORTION OF BANKRUPT HOUSEHOLDS WITH NO HEALTH INSURANCE, BY FILING STATUS, 1999



Note: Reasons may overlap.

Source: Consumer Bankruptcy Project: Phase III (1999).

Once again, however, when we compute the actual number of bankrupt families without insurance rather than the proportion of such families within each subgroup, the relative numbers change. Figure 6 illustrates this point.

Reanalyzing the responses by age group also indicates that health coverage—including Medicare—does not prevent health-related insolvency. In theory, Medicare should decrease seniors' need to use bankruptcy for medical reasons. If that were the case, a smaller proportion of the elderly debtors should have identified medical reasons for bankruptcy than their younger counterparts. At the same time, the youngest debtors, while least likely to be insured as a general matter, should be facing fewer health problems and thus should be less likely to identify medical reasons for bankruptcy. As previously noted, however, the data demonstrate that elderly debtors were far from immune from health-related financial problems and, with nearly half of the debtors aged sixty-five and older listing a medical reason for filing, were more likely than their younger counterparts to have bankruptcy filings related to medical problems.<sup>110</sup>

We might speculate that these debtors should not have relied so heavily on insurance. Perhaps some of these underinsured families could have fended off bankruptcy in the aftermath of a medical crisis if they had the requisite savings or if they worked out longer repayment plans with their creditors. It is not possible, however, to determine from this study how much saving or "belt tightening" would have been required to keep families with high medical bills, job losses, and median incomes of \$28,000 out of bankruptcy.<sup>111</sup>

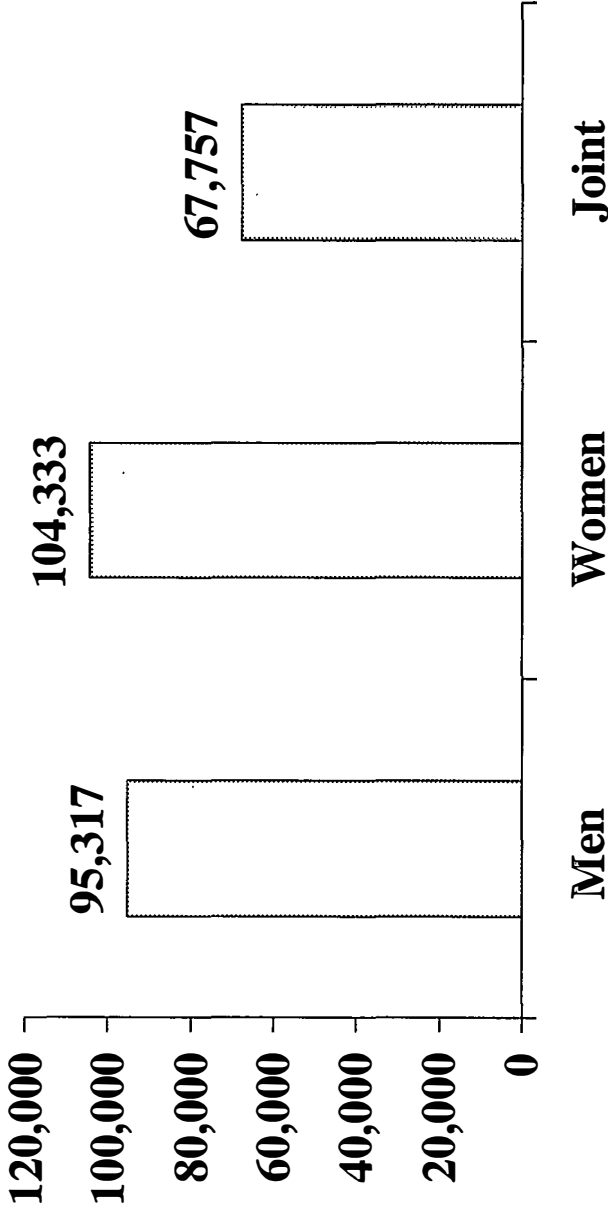
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[www.federalreserve.gov/pubs/Feds/1999/199919/199919pap.pdf](http://www.federalreserve.gov/pubs/Feds/1999/199919/199919pap.pdf); see also Thorpe, *supra* note 102, at 16 (tracing insurance rates of men and women).

<sup>110</sup> See *supra* notes 92-95 and accompanying text. A Consumer Union study found that more than half of families headed by people over age sixty-five pay more than ten percent of their income for health care. See Gail Shearer, Consumers Union, *Hidden From View: The Growing Burden of Health Care Costs* (1998), Executive Summary at <http://www.consumersunion.org/health/0122exec.htm>.

<sup>111</sup> For a discussion of the extent to which households engage in precautionary savings vis-à-vis unemployment risk (and the widely varying conclusion on precautionary savings), see generally Christopher D. Carroll, Karen E. Dynan & Spencer D. Krane, *Unemployment Risk and Precautionary Wealth: Evidence from Households' Balance Sheets* (Fed. Reserve Bd., Finance and Economics Discussion Series No. 1999-15, 1999), <http://www.federalreserve.gov/pubs/feds/1999/199915/199915pap.pdf>.

FIGURE 6: ESTIMATED NUMBER OF BANKRUPT HOUSEHOLDS WITH NO HEALTH INSURANCE, BY FILING STATUS, 1999



Source: Consumer Bankruptcy Project: Phase III (1999).

### III BEYOND BASIC INSURANCE: HEALTH CARE FINANCE ISSUES

The data suggest that for nearly half a million families, health care insurance or Medicare was inadequate to insulate them from the most serious financial effects of a medical problem. For the debtors in the bankruptcy sample, the presence or absence of health insurance made no statistically significant difference in predicting whether a family would identify a medical reason or substantial medical debts when they filed. The health insurance rates among those with medical reasons for filing and among those with other reasons for filing were statistically indistinguishable. Of course, the insurance policies themselves might have been different, resulting in different coverage. It also may be the case that many Americans have gaps in their coverage, and those in bankruptcy after a medical problem are those who discovered the gaps in the most painful way.

What is left uncovered by Medicare or private insurance that contributes to financial downfall? We hypothesize that there are several basic kinds of problems: uncovered family members, inadequate coverage of medical costs, and employment difficulties.

#### *A. Family Members Without Coverage*

The space on the questionnaire was limited, as was the time the interviewees had to give their answers. As a result, we were unable to identify how many bankrupt families fell within various subcategories of insurance problems. We asked whether the debtor(s) had any insurance at the time of the filing.<sup>112</sup> This meant that the answer would be “yes” for a family, even if a child had been born with a serious medical problem and was not covered by the parents’ insurance, or if the poor health of a spouse meant that a nondebtor spouse was excluded while the wage earner and children were covered. For other families, the answer would be “yes” even if the principal worker in the family was covered, but dependent children at college were not. Adult children with no insurance, or elderly parents with only Medicare, may turn to families for help paying medical bills, but those expenses can not be passed along to the debtor’s insurance company.

Recall that Figure 4 illustrated a notch in the data, showing a peak in giving a medical reason for filing among the 45-54 age group, followed by a decline in the 55-64 age group.<sup>113</sup> This finding approximates a pattern identified in the 1991 data reported by Sullivan,

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<sup>112</sup> See *infra* app. 2 at question 6.

<sup>113</sup> See *supra* fig.4.



Warren, and Westbrook.<sup>114</sup> These data may suggest that it is health care problems for family members, particularly those unlikely to be covered by the wage earners' insurance, that drag the family down financially. Debtors in this age group not only face their own health care needs; they also may be trying to help finance the health care of their children and their parents. This age group therefore seems to be most vulnerable to the widest range of financial stresses related to health care. After the high point of the vulnerability of debtors in this age group, the obligations to children and parents ultimately decline as children become more independent and as elderly parents die, although the debtors' own health problems may intensify. We speculate that this rise and fall in latter middle age is related to different groups within the family calling on the primary wage earners for help.

### *B. Inadequate Coverage of Direct Medical Costs*

With respect to uncovered direct medical costs, these data cannot help us to distinguish between the various types of direct medical costs that might be left uncovered, although it is possible to draw inferences by working backward from what we know is *not* covered by some insurance plans. Some of the financial problems unfold slowly over time. High copayments for chronic problems may erode a family's financial well-being. Lack of coverage for expensive prescription drugs may mean that every month the family simply spends more than it takes in and eventually owes bills surpassing the family's annual income.<sup>115</sup> Expenses incurred for medical devices and supplies due to certain conditions—testing equipment for diabetes, hearing aids and eyeglasses, special pads for the incontinent—may stress a family budget that is already stretched to the breaking point. Some of the financial problems come in a quick blow. It is possible for a stay in the hospital or treatments for diseases or accidents to mount into the hundreds of thousands of dollars in a matter of weeks, so that a family with a lifetime cap on medical treatments that once sounded large can be facing six-figure medical bills.

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<sup>114</sup> See Sullivan, Warren & Westbrook, *supra* note 1, at 165 fig.5.4.

<sup>115</sup> Cf. Press Release, U.S. Dep't of Health & Human Servs., Health Care Spending Growth Rates Stay Low in 1998, Private Spending Outpaces Public (Jan. 10, 2000) ("Prescription drug spending continued to record the biggest increase of any health spending sector in 1998, up by 15.4 percent . . . . The cost of prescription drugs has risen at double-digit rates for the past several years."), <http://www.hhs.gov/news/press/2000pres/20000110.html>. A study by FamiliesU.S.A., released in April 2000, found that prices for the fifty drugs most frequently used by seniors increased, on average, at nearly double the rate of inflation. See FamiliesU.S.A., Pub. No. 00-103, *Still Rising: Drug Price Increases for Seniors 1999-2000*, at 2 (2000), <http://www.familiesusa.org/pdrug.pdf>.

We speculate that most families learn about caps on their coverage and how quickly their coverage can be exhausted only after a serious problem has struck. Preexisting conditions may be written out of health insurance policies, and the conditions most likely to be excluded are those that can prompt large medical bills. Families may not focus on the shortfalls of their health insurance coverage until it is too late. For example, one survey conducted in 1993 found that twenty-one percent of insured Americans were not sure if their insurance limited the total amount of benefits they could receive, and thirty-seven percent were not sure if their insurance covered nursing home care.<sup>116</sup> These data suggest that consumers may see themselves as “insured” without fully appreciating just how limited their protection is.

### C. *Income Effects of Medical Problems*

In addition to the direct costs of medical bills, one of the most significant financial effects of medical problems may be an indirect one: employment difficulties. Job-related financial problems have the potential to impose far greater financial strain than the direct costs of medical care. Even if insurance pays every cent of the direct medical costs, recovery from an illness or accident can cause a temporary problem—a few lost work days—or more permanent problems with longer-term professional repercussions. The financial effects of heart attacks and strokes, progressively worsening asthma, or cancer only may begin with medical bills. Such medical problems may leave a wage earner with a sharply reduced or nonexistent earning capacity. Income supplement programs, such as social security disability and workers’ compensation, offer some assistance, but the programs are spotty in coverage and fall short in providing benefits.<sup>117</sup>

The income effects may be felt in other ways as well. When a child or elderly parent falls ill, the family unit may experience a de-

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<sup>116</sup> Robert J. Blendon et al., *The Beliefs and Values Shaping Today’s Health Reform Debate*, *Health Aff.*, Spring 1994, at 274, 281; see also Shearer, *supra* note 110, at 1 (“The huge variation in health care costs and the disproportionate share that is paid by the sick is not even on the radar screen for most consumers.”). In 1997, 17.2% of all national health expenditures were paid for by individual citizens. John K. Inglehart, *The American Health Care System—Expenditures*, 340 *New Eng. J. Med.* 70, 72 (1999). For Medicare beneficiaries over the age of sixty-five and below the federal poverty level, a significant portion of their incomes was spent on out-of-pocket health care costs: thirty-five percent for those eligible for Medicaid and fifty percent for those who did not receive Medicaid. *Id.*

<sup>117</sup> For more discussion of income supplement programs, see Sullivan, Warren & Westbrook, *supra* note 1, at 157-63; see also Wilfred T. Masumura, *Moving Up and Down the Income Ladder 2-4* (U.S. Census Bureau, Current Population Reports No. P70-56, 1996) (discussing effect of unemployment benefits, Social Security, and means-tested benefits programs on income-to-poverty ratio in individual households), <http://www.census.gov/prod/2/pop/p70/p70-56.pdf>.

cline in income. Illness of a dependent family member may cause an able-bodied person to leave a job in order to provide care. The questionnaires completed are full of accounts of mothers who quit their jobs when babies required extensive surgery in distant cities, and of adult children who cut back their work hours to care for an ailing parent. The financial consequences go beyond trying to pay the bills, and include time lost from work to care for children, siblings, and parents with serious medical problems. These cases may become more common as our health care system increasingly releases people from hospitals for convalescence while they require substantial ongoing care. The data in Figure 4 help illustrate that families are particularly vulnerable to bankruptcy when they are responsible for the care of others.

Of course, these data tell us only about correlations, not about causation. It is possible that job problems and medical problems are linked differently for some families. For example, a family may lose its health insurance when the primary wage earner loses a job, leaving the whole family vulnerable to medical bills.<sup>118</sup> The period of unemployment is typically over by the time the family ends up in bankruptcy, and health insurance may be available once again, but the family can be left with health care costs incurred during the period without insurance.

Among the debtors who identified a health care problem, the data reveal the associated risk of an income problem. More than eight out of ten (81.5%) of those with a medical problem also identified a job problem. The 1991 data reported in Sullivan, Warren, and Westbrook were similar: 79.2% of those with a medical problem also identified a job problem.<sup>119</sup>

The data show that the relationship between medical and income problems has persisted throughout the 1990s, and the number of debtors who suffer from both has jumped. In 1991, about 15.3% of the whole sample identified both job and medical reasons for their bankruptcy filings.<sup>120</sup> By 1999, the comparable proportion was more than twice as large. More than a third of our sample (37.7%), or an estimated 485,115 households in 1999, had both a medical problem and a

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<sup>118</sup> Notwithstanding federal legislation to make health insurance "portable," a job loss—and the resulting loss of income to pay for insurance—nonetheless may leave some families without insurance.

<sup>119</sup> See Sullivan, Warren & Westbrook, *supra* note 1, at 158 fig.5.3.

<sup>120</sup> *Id.* The 1991 data reported in Sullivan, Warren & Westbrook, *supra* note 1, reflect similar results, but they are not directly comparable to the results of the 1999 survey because the 1991 survey asked debtors only an open-ended question about why they filed. In 1991, approximately one in five families listed medical problems as a reason for their bankruptcy filing.

job problem.<sup>121</sup> This means that by 1999, more than one in three families filing for bankruptcy were trying to cope simultaneously with the increased expenses of a medical problem and a reduced family income.

Job problems do not stop at the putative retirement age. Many older Americans continue to work full-time, and many pick up part-time work in order to cover their expenses. The 1991 data showed that the debtors aged sixty-five and older were equally likely to explain their bankruptcy filings in terms of a medical problem (thirty-six percent) or a job problem (thirty-six percent).<sup>122</sup> These data suggest that the financial fallout from a serious medical problem cannot be held off with a basic coverage health insurance plan. The amount of medical debt that is not covered, combined with the income effects of a serious medical problem, leave many families vulnerable to financial collapse, notwithstanding their status as "insured." These data show that many families with some health insurance are also just an accident or an injury away from financial disaster.

#### IV

#### POLICY IMPLICATIONS

The substantial number of medically related bankruptcy filings—particularly among the elderly and women filing singly—sheds light on the limitations of our current system of health care finance. Even if an omniscient observer might challenge some of the debtors' own attributions of their medical problems and debts, the data compiled from Phase III of the Consumer Bankruptcy Project nonetheless reinforce the widespread concern of legislators, policymakers, and American families that the costs and consequences of illness or injury are outstripping the current health care financing system. The concern should be increased by the observation that these bankrupt families are not unique. They represent only a fraction of middle-class families who, with little margin for error in their budgets, must stay physically healthy to remain financially healthy. We cannot estimate how many millions of additional families, with financial profiles only slightly better than those of the bankrupt families, currently are weathering the storm of a health care crisis. Nor can we estimate how many others are just an accident or injury away from future insolvency.

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<sup>121</sup> Of our sample, 68.9%—an estimated 886,590 households in 1999—identified a job problem (e.g., unemployment, layoff, cutback in hours, reduced salary, and changed status, such as from employee to independent contractor). Nearly eight out of ten debtors in our sample (78.2%, or an estimated 1,006,268 households, in 1999) identified either a job or a medical problem.

<sup>122</sup> Sullivan, Warren & Westbrook, *supra* note 95, at 5.

### *A. Implications for the Health Care Finance System*

To the extent that health policy debates focus on providing modest health insurance coverage to all families, these data suggest that the proposed solution may be somewhat wide of the mark. Basic health insurance packages will ensure that health care is provided and paid for; they will not assure the security of families beset by health problems in light of the direct and indirect financial effects they are likely to face. Exclusions for family members, for preexisting conditions, and for various treatments and supplies, may be a matter of economic necessity for health insurers, but they leave families to find other ways to cope with the shortfall. The effect of insurance coverage caps on families with the most serious problems echoes through these data.

Perhaps the most startling finding from the data is that the income effects of health care problems, especially over the long term, are often more financially devastating than the medical bills themselves. The data suggest that long-term disability insurance, and other forms of income support for those facing a serious medical problem, warrant more attention if the goal is to prevent families from collapsing financially in the aftermath of a serious health problem. Until income effects are addressed directly, middle-class families will remain at risk for financial devastation following serious illnesses or accidents to themselves or their family members.

### *B. Implications for the Bankruptcy System*

Finally, we return to the subject with which we began: the bankruptcy system itself. We studied the bankruptcy system in an effort to improve our general understanding of families in financial crisis. We included some medical questions along with several other financial questions. We did not undertake this study with the express purpose of uncovering the fallout from inadequate health care financing, but that is what we found. In effect, we uncovered that the bankruptcy system is the insurer of last resort to families and individuals who cannot pay health-care-related costs. Whether their bills were insurmountable or their incomes had dipped precipitously, they turned to bankruptcy to erase some of their debts and to restructure others, taking the opportunity to regroup financially. Even with debt relief, it is possible that they never will return to their pre-illness financial condition. The bankruptcy system nonetheless gave these families the opportunity to put the brakes on their slide out of the middle class.

Any changes to the bankruptcy law system that affect hard-pressed debtors also will have an effect on bankruptcy's function as

the insurer of last resort. Over the past several years, Congress has considered legislation that would restrict the benefits of filing for bankruptcy and increase the complexity of the bankruptcy process.<sup>123</sup> To the extent that bankruptcy reform increases the cost of filing and establishes additional barriers to discharge, the price of last-resort insurance will rise. Bankruptcy policymakers, no less than health care economics policymakers, may wish to examine the impact of systemwide changes on families dealing with the financial aftermath of illness and accidents.

In addition, the bankruptcy legislation considered over the past several years also adjusts—both directly and indirectly—entitlements of various groups of creditors.<sup>124</sup> The consumer credit industry, which has lobbied actively for the proposed legislation, has had a significant hand in shaping its contours.<sup>125</sup> Not surprisingly, this group is likely to be the primary beneficiary of many of the resulting changes in entitlements and “special interest” provisions. Special interest provisions are problematic from a fairness perspective, especially in the context of a collective proceeding such as bankruptcy. Institutional lenders can position themselves to obtain even greater advantages by, for example, taking security interests in consumer goods of nominal value, such as clothing and small appliances. Health care providers, of course, cannot protect themselves by taking similar interests in body parts. The consequences of bankruptcy reform, coupled with practical realities, are that health care providers will get a smaller portion of a family’s repayment dollars. At a time when families increasingly turn to bankruptcy to deal with health care problems, it is important to ask whether public policy is served by placing the interests of the consumer credit industry above the interests of critical health care providers.

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<sup>123</sup> Both the House and Senate passed the Conference Report on H.R. 2415 at the end of the 106th Congress. That omnibus bill was pocket vetoed by President Clinton. See Memorandum of Disapproval (Dec. 21, 2000), 2000 WL 29592479. As of this writing in the beginning of the 107th Congress, the House has passed a similar bill, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2001, H.R. 333, 107th Cong. (2001), <http://thomas.loc.gov/>, and the Senate has passed the Bankruptcy Reform Act of 2001, S. 420, 107th Cong. (2001), <http://thomas.loc.gov/>. See Philip Shenon, *Senators Adopt Tougher Rules on Bankruptcy*, N.Y. Times, Mar. 16, 2001, at A1.

<sup>124</sup> See 146 Cong. Rec. S11,621-42 (daily ed. Dec. 6, 2000) (floor debate on Bankruptcy Reform Act of 2000); 146 Cong. Rec. S11,683-11,730 (daily ed. Dec. 7, 2000) (floor debate and final vote approving same).

<sup>125</sup> Bankruptcy-Reform Bill Dies with a “Pocket Veto,” Wall St. J., Dec. 20, 2000, 2000 WL-WSJ 26620630; Editorial, *Bankruptcy Bipartisanship*, Wash. Post, Dec. 15, 2000, at A40; Danielle T. Furfaro, *Targeting Abusers of Credit*, Times Union (Albany, N.Y.), Dec. 3, 2000, at C1; *Tending to the Banks*, U.S. Banker, Dec. 2000, at 21.

### CONCLUSION

Bankruptcy often is viewed as a discrete socioeconomic issue, simply a problem in and of itself. In its role as insurer of last resort, however, bankruptcy also speaks volumes about the pervasive financial risks borne by individual families. The bankruptcy files provide stark documentation of the economic problems families encounter when medical problems mount and incomes fall. These bankruptcy data take us a step closer to understanding the uneasy relationship between physical health and financial health.

## APPENDIX 1 DATA AND METHODS

The data reported here were generated by questionnaires collected for Phase III of the Consumer Bankruptcy Study. The study was conducted during the first quarter of 1999, in the bankruptcy courts of eight federal judicial districts: the Northern District of California, the Northern District of Illinois, the Eastern District of Kentucky, the Southern District of Ohio, the Eastern District of Pennsylvania, the Middle District of Tennessee, the Northern District of Texas, and the Eastern District of Wisconsin. These districts represent six appellate circuits, and among them they accounted for 13.2% of the nearly 1.3 million nonbusiness bankruptcies filed in calendar year 1999.<sup>126</sup>

In each district, we sought both the permission of the bankruptcy judges to conduct our study and the cooperation of the U.S. Trustees. We assured them that the data collected would be aggregated statistically and that no debtor would be identifiable from the data. During the waiting period before a debtor's case was called at the meeting of creditors,<sup>127</sup> volunteers approached each individual or couple and invited them to complete the survey. A cover letter assured the filers that the data would be anonymous and confidential.<sup>128</sup> The letter also made clear that answering the survey was completely voluntary and would not affect the progress of the respondent's case. We also prepared a letter addressed to debtors' counsel to accompany the questionnaire, providing potential respondents who were uncertain about completing the questionnaire the opportunity to ask their counsel for advice.

The volunteer filers were instructed that the filers asked to participate in the study were individuals or couples filing in Chapter 7 or Chapter 13. As it turned out, our surveys also were completed by nine nonbusiness petitioners in Chapter 11, and by two petitioners in Chapter 12, but these eleven cases have been eliminated from our analysis. Filers using a business style, such as a corporation or partnership, were not eligible for the study. Business Chapter 13 cases, however,

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<sup>126</sup> In calendar year 1999, there were 1,281,581 nonbusiness bankruptcies filed and an additional 5903 business Chapter 13 cases filed. News Release, *supra* note 4. These two groups of filings were included in our study. In the eight federal judicial districts we studied, there were 169,916 total nonbusiness cases and business Chapter 13 cases filed in 1999. *Id.*

<sup>127</sup> See 11 U.S.C. § 341(a) (1994) (requiring meeting of debtor with her creditors and trustee).

<sup>128</sup> See *infra* app. 2.



are included in light of the fact that only individuals—not corporate entities—are permitted to file in Chapter 13.<sup>129</sup>

The questionnaire did not contain any uniquely identifying information such as names, addresses, social security numbers, or case numbers. The decision not to include identifying information precludes linking the answers on the questionnaire to the petitions and schedules filed with the court. We hoped that the greater anonymity would encourage more people to complete the questionnaire. The questionnaire included about twenty-eight questions, but most of these questions had precoded answers<sup>130</sup> so that the time commitment for completing the form was minimal. For a couple filing jointly, the questionnaire asked for information concerning both spouses. From our pre-test, we estimated that the time required to complete the instrument was about five minutes.

We sampled a different number of debtors from each district to reflect the differences in the total number of consumer debtors in the district. We collected more cases from districts with a greater number of filings and fewer cases from districts with lower filings. The target for the district was based on the number of cases filed in each Chapter in the district in the preceding year. For districts where more questionnaires were returned than were needed for the study, we sampled randomly among the questionnaires for our final database. To illustrate, in 1998 the Administrative Office of the U.S. Courts recorded four times as many Chapter 7 filings in the Northern District of Illinois as there were in the Eastern District of Kentucky.<sup>131</sup> Thus, in our database there are four times as many Chapter 7 cases from the Northern District of Illinois as from the Eastern District of Kentucky. The final sample size for this report is 1496 cases (excluding outliers and the eleven cases filed in Chapter 11 or Chapter 12). The total number of debtors (counting joint petitions as two debtors) is 1970. With the exception of two districts, the data collection was completed in February 1999.

Student coders were hired to enter the precoded answers from the questionnaire into a spreadsheet. Occupational data were coded by one of the investigators using the 1970 U.S. Census occupational codes. The spreadsheet was imported into the S.A.S. statistical package for analysis. A five-page codebook incorporates the codes developed for the study.

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<sup>129</sup> 11 U.S.C. § 109(e) (1994) (defining eligibility for Chapter 13).

<sup>130</sup> See *infra* app. 2.

<sup>131</sup> News Release, Admin. Office of the U.S. Courts, Increase in Bankruptcy Filings Slowed in Calendar Year 1998 (Mar. 1, 1999), [http://www.uscourts.gov/Press\\_Releases/CY98BK.pdf](http://www.uscourts.gov/Press_Releases/CY98BK.pdf).

An important issue with any data collection is the extent to which people who volunteer to answer questions and participate in the study differ from the people who refuse to answer the questions. We made several efforts to identify whether the data were affected by a selection bias by comparing our data with publicly available information concerning bankruptcy filings.

One comparison centers on the proportion of filings that are in Chapter 7. In the country as a whole, both in 1998 and 1999, approximately seventy percent of nonbusiness filings were in Chapter 7,<sup>132</sup> compared with seventy percent in our total sample. In five of our eight districts, the proportion of Chapter 7 filings in our sample lies within five percent of the proportion recorded for that district in 1998. The one district in which we appear to have an overrepresentation of Chapter 7 (or an underrepresentation of Chapter 13) is in the Eastern District of Pennsylvania. In 1998, sixty-three percent of nonbusiness filings in that state were in Chapter 7, compared with eighty-seven percent of our sample.<sup>133</sup> This difference of twenty-four percentage points indicates that we had too few Chapter 13 cases for this district. We did a second comparison of the reported sex of filers with the sex of respondents judged from the dockets in two districts. The Northern District of Texas and the Eastern District of Pennsylvania have online dockets. Using these dockets, it was possible to estimate the proportion of joint filers and the relative proportion of male and female filers among all filers. These numbers then could be compared with the information on sex and filing status provided by our respondents. These differences between the two districts are largely offsetting.

The comparisons, Chapter of filing, sex of the petitioner, and joint or single status of filing indicate that the study data, while not a perfect representation of the filings in 1998, incorporate relatively small biases that are often offset within the database as a whole.

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<sup>132</sup> News Release, *supra* note 4; News Release, *supra* note 131.

<sup>133</sup> See *supra* note 4.

APPENDIX 2  
CONSUMER BANKRUPTCY SURVEY

You have been selected to be part of a study of consumer bankruptcy. This study is intended to provide factual information to assist lawyers, judges, and law-makers to understand who the people are who file for bankruptcy and what their problems are.

Two professors are conducting this survey. Dr. Teresa Sullivan is a sociologist at The University of Texas at Austin and Prof. Elizabeth Warren is a law professor at Harvard University. They have frequently studied people in bankruptcy.

No other person, sponsor, or organization has a financial interest in this study.

Your cooperation in this study is entirely voluntary. You may skip any question you do not wish to answer. Your refusal to participate in this study will not in any way affect your bankruptcy case or your future relations with either The University of Texas at Austin or with Harvard University. We are interested in a statistical picture of bankruptcy. You are important to that picture, because the picture will not be accurate without your response. But because we are interested in statistical descriptions, we do not need either your name or your case number.

The questionnaire takes about five minutes, on average, to complete. You are welcome to add any comments or clarification, if you wish. Your attorney may assist you. Please complete the questionnaire before leaving, and return it to the person who has given it to you.

[Professors Sullivan and Warren provided their names, addresses, and telephone numbers.]

DEBTOR QUESTIONNAIRE

Directions: This form should be completed for any person filing for bankruptcy in any chapter. In the case of a joint filing, questions 1-8 should be answered for both petitioners. Completion of this form is voluntary. This form is completely anonymous; no case number or name will be associated with this questionnaire.

<u>Question</u>	<u>First or Principal Petitioner</u>	<u>Second Petitioner (if joint)</u>
1. Sex	Male Female	Male Female
2. Age (print each person's age at last birthday.)	_____	_____

3. Current marital status (check one box for each person.)	Married Separated Widowed Divorced Never married	Married Separated Widowed Divorced Never married
3a. Has this person experienced a <i>change</i> in marital status since 1 Jan. 1997?	Yes No	Yes No
4. Education (check one box for highest level of school COMPLETED)	No school 8th grade or less 9th, 10th, or 11th grade 12th grade, no diploma high school graduate some college bachelor's degree advanced degree	No school 8th grade or less 9th, 10th, or 11th grade 12th grade, no diploma high school graduate some college bachelor's degree advanced degree
5. During the past week, has this person worked at least one hour for pay or profit?	Yes No	Yes No
5a. Since 1 Jan. 1997, has this person experienced an interruption of at least two weeks in work-related income? (For example, through layoff or illness.)	Yes No Not employed at all since Jan. 1997	Yes No Not employed at all since Jan. 1997
5b. If not currently holding a job, did this person actively SEEK work during the past four weeks?	Yes, sought work No Has a job now	Yes, sought work No Has a job now
5c. Since January 1997, has this person's work changed in any of these ways?	No change Income changed: more less Hours changed: more fewer Has not been employed since January 1997	No change Income changed: more less Hours changed: more fewer Has not been employed since January 1997
5d. If employed, what kind of work does this person do?	_____	_____
5e. If employed, how many years with the same employer?	_____	_____
5f. At any time during the past two years, was this person self-employed?	Yes No	Yes No
6. Does this person have any form of medical insurance?	Yes No	Yes No
6a. Has this person had medical bills not covered by insurance in excess of \$1000 during the past two years?	Yes No	Yes No

