

Saint Louis University Law Journal

Volume 51

Number 2 *From Risk to Ruin: Shifting the Cost of Health Care to Consumers (Winter 2007)*

Article 5

3-22-2007

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Melissa B. Jacoby

The University of North Carolina School of Law

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Recommended Citation

Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 St. Louis U. L.J. (2007).

Available at: <https://scholarship.law.slu.edu/lj/vol51/iss2/5>

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THE DEBTOR-PATIENT REVISITED

MELISSA B. JACOBY*

INTRODUCTION

Medical debt has reached “public problem” status. In a recent poll, 44% of respondents said that they worry about falling deep into debt because of medical expenses.¹ The news media has focused on hospital billing and collection practices and told stories about patients repaying at high rates of interest for years or being thrown into jail.² Governmental authorities are linking hospitals’ debt collection practices with their entitlement to tax exemptions.³ A new analysis of bankruptcy filers in the Panel Study of

* Professor of Law, University of North Carolina at Chapel Hill. J.D., B.A., University of Pennsylvania. Thanks to Elisha Johnson for research assistance, Nick Sexton for library support, the University of North Carolina School of Law for financial assistance, and Sidney Watson for inviting me to participate in this symposium. I am grateful to the 2001 Consumer Bankruptcy Project for generously sharing the data presented in Table 1.

1. See GREENBERG QUINLAN ROSNER & PUBLIC OPINION STRATEGIES, PUBLIC RECOGNIZES DEBT AS A FAST GROWING PROBLEM IN THE U.S. fig. 2 (July 19, 2006), available at http://www.americanprogress.org/kf/debt_survey_pdf.pdf; see also Henry J. Kaiser Family Foundation, *The Public on Health Care Costs*, KAISER PUBLIC OPINION SPOTLIGHT, Dec. 2005, at 1, available at http://www.kff.org/spotlight/healthcosts/upload/Spotlight_Dec05_health_costs.pdf (reporting that health care costs were mentioned by 39% in response to a question asking what the most important health problem for the government to address was). Indeed, polling data suggest that Americans are more concerned about medical debts than job security. See AM. ENTERPRISE INST., *THE STATE OF THE AMERICAN WORKER 2006: ATTITUDES ABOUT WORK IN AMERICA* (Aug. 29, 2006), available at <http://www.aei.org/publicopinion17/>. AEI reports that an April 2006 Gallup poll indicated that only 3% of respondents thought it was very likely that they would lose their jobs in the next year, and 7% thought it was fairly likely. *Id.* at 10. Around 60% of the April 2006 survey participants also seemed to think that if they did lose their jobs, it was either very likely or somewhat likely that they would get jobs as good as their current jobs. *Id.* at 11. However, in a 2005 Gallup poll, a higher percentage of respondents (28%) were worried that their benefits would be reduced. *Id.* In an August 2005 poll, 22% reported that they had been laid off or fired in the past five years. *Id.* at 12.

2. See generally Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 538–539 (2006); Carol Pryor, *The Hospital Billing and Collections Flap: It's Not Over Yet*, 2005 J. HEALTH CARE COMPLIANCE 25, 25 (2005).

3. See John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433 (2007); Nancy M. Kane, *Tax-Exempt Hospitals: What is their Charitable Responsibility and How Should it Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459 (2007).

Income Dynamics sample focuses almost exclusively on medical debt.⁴ Health policy think tanks and advocacy groups suggest that medical debt problems can strike anyone and everyone.⁵ In addition to being cited in proposals that propose more comprehensive health insurance,⁶ law- and policy-makers are citing medical debt and medical bankruptcy studies to justify changing the legal treatment of medical debt.⁷

Now that medical debt is receiving the attention it deserves, it is time to refine and slightly reframe the debate in several respects. In Part I of this symposium contribution, I start by reviewing data on out-of-pocket medical costs in the general population. The data suggest the absence of a monolithic medical debt issue. Instead, they present several distinct issues. There are some cases of truly “catastrophic” illness in the form of very expensive diseases.⁸ But then we find a significantly larger cohort of people who struggle financially with out-of-pocket expenses that are relatively modest. For the most part, data on bankruptcy filers further emphasize this divide.⁹

4. Aparna Mathur, *Medical Bills and Bankruptcy Filings 5–7* (Am. Enterprise Inst., July 19, 2006), available at <http://www.aei.org/publication24680>.

5. See *infra* Part I.A.

6. See, e.g., David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, W5-63, W5-72 (2005), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.pdf> (“Only broad reforms can address these problems.”).

7. See, e.g., Medical Bills Interest Rate Relief Act, H.R. 1238, 109th Cong. §§ 3, 4 (2005) (proposing limiting interest rates and prohibiting credit reporting). See generally *infra* Part IV.

8. Catastrophic medical expense has been defined variously in the literature. For an example of a recent definition of “catastrophic” expense, see Ke Xu et al., *Household Catastrophic Health Expenditure: A Multicountry Analysis*, 362 THE LANCET 111, 111 (2003) (defining catastrophic as when “a household’s financial contribution to the health systems exceed 40% of income remaining after basic subsistence needs have been met”). For a review of other definitions, see Gong-Soog Hong & Soo Yeon Kim, *Out-of-Pocket Health Care Expenditure Patterns and Financial Burden Across the Life Cycle Stages*, 34 J. CONSUMER AFF. 291, 294 (2000) (presenting tests and stating that “researchers typically define 10 percent to 20 percent of income as a catastrophic health care expenditure.”); Michael Schwartz et al., *Catastrophic Illness Expense: Implications for National Health Policy in the United States*, 12 SOC. SCI. & MED. 13 (1978); Pamela Farley Short & Jessica S. Banthin, *New Estimates of the Underinsured Younger Than 65 Years*, 274 J. AM. MED. ASS’N. 1302, 1303 (1995); Leon Wyszewianski, *Families With Catastrophic Health Care Expenditures*, 21 HEALTH SERVS. RES. 617, 618–20 (1986) [hereinafter Wyszewianski, *Families With Catastrophic Health Care Expenditures*]; Leon Wyszewianski, *Financially Catastrophic and High-Cost Cases: Definitions, Distinctions, and Their Implications for Policy Formulation*, 23 INQUIRY 382, 382 (1986). Other researchers have used the terms “lacking financial protection” or “underinsured.” See, e.g., Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, HEALTH AFF., Jun. 14, 2005, W5-289, W5-291–92 (2005), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1>; Hugh Waters et al., *Measuring Financial Projection in Health in the United States*, 69 HEALTH POL’Y 339 (2004).

9. See *infra* Part I.B.

Part II explores factors that may be compounding the difficulties associated with even non-catastrophic expenses for average American families. I consider three categories of explanations. First, illness and injury have indirect financial effects in the short term and long term.¹⁰ Second, common and understandable coping mechanisms ultimately may exacerbate the financial and perhaps health impact of even smaller medical bills.¹¹ Third, recent research suggests that considerable numbers of households with middle-class attributes cycle through periods of poverty and eligibility for government assistance.¹²

Recognizing multiple ways in which medical debt and problems affect household finances should shape not only how we think about health care finance reform, but also how we think about legal regulation of medical debt within our current healthcare finance system. I briefly address these issues in the conclusion of this symposium contribution.

I. OUT-OF-POCKET MEDICAL EXPENSES AND DEBTOR-PATIENT PARADIGMS

A. *Debtor-Patients in the General Population*

When we think of catastrophic health problems, we tend to focus on “unusually expensive illnesses.”¹³ As noted at the outset of this paper, a large proportion of the population fears this happening to themselves.¹⁴ Apparently, people who consider themselves middle class and have health insurance now believe it is possible that they could go—to use the title of this symposium—“from risk to ruin” when they get sick.

To get a sense of the big picture of the medical expense risks middle class households face, I start with analyses of data from the Medical Expenditure Panel Survey (MEPS), a nationally representative longitudinal survey that tracks out-of-pocket health care costs of the non-institutionalized civilian population.¹⁵ According to an analysis from the 2003 MEPS survey, 2.8% of non-elderly individuals lived in families with out-of-pocket expenditures (including insurance premiums) exceeding \$10,000 that year.¹⁶ Fourteen

10. *See infra* Part II.A.

11. *See infra* Part II.B.

12. I refer here primarily to the work of Mark Rank and Thomas Hirschl. *See infra* Part II.C.

13. CONG. BUDGET OFF., CATASTROPHIC MEDICAL EXPENSES: PATTERNS IN THE NON-ELDERLY, NON-POOR POPULATION xiii (Dec. 1982), *available at* <http://www.cbo.gov/ftpdocs/51xx/doc5134/doc37-Entire.pdf>.

14. *See* GREENBERG QUINLAN ROSNER & PUBLIC OPINION STRATEGIES, *supra* note 1, at fig. 2.

15. *See* Didem Bernard & Jessica Banthin, *Out-of-Pocket Expenditures on Health Care and Insurance Premiums Among the Non-Elderly Population, 2003*, STATISTICAL BRIEF NO. 121 (Med. Expenditure Panel Survey, Rockville, Md.), Mar. 2006, *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st121/stat121.pdf.

16. *Id.*

percent were in families spending more than \$5,000.¹⁷ Yet, more than four in ten (43%) lived in families with out-of-pocket expenditures exceeding \$2,000.¹⁸ Already, we can make two general observations. First, the likelihood of absolute dollar-based catastrophic expenses is low in any given year.¹⁹ Second, incurring several thousand dollars of annual medical-related financial obligations should be perceived as common rather than extraordinary.

Of course, the financial burden of medical expense is in part a function of income.²⁰ Even though the research suggests that higher income people tend to spend greater *dollar* amounts out-of-pocket than lower income households,²¹ lower income people are at far greater risk of spending significant *proportions* of their income on health care.²² For example, Johns Hopkins researchers have found that nearly 17% of poor families pass the threshold of spending more than 40% of family income on health care, whereas only 0.2% of families with incomes at or above 200% of the Federal Poverty Level would meet that catastrophic threshold.²³ In another analysis using 2005 MEPS data and a lower catastrophic threshold, researchers found about 19% of families had total out-of-pocket expenditures greater than 10% of their incomes, but again that burden was not evenly distributed.²⁴ For middle-income, non-elderly

17. *Id.*

18. *Id.*

19. Much earlier work found that a multi-year analysis somewhat expands the likelihood of catastrophically expensive illness. See CONG. BUDGET OFF., *supra* note 13, at xiv.

20. See Ke Xu et al., *supra* note 8, at 112 (measuring catastrophic as out-of-pocket expenses being greater than 40% of income remaining after most basic subsistence needs have been met); see also Jessica S. Banthin & Didem M. Bernard, *Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003*, 296 J. AM. MED. ASS'N 2712 (2006).

21. See Bernard & Banthin, *supra* note 15; Hong & Kim, *supra* note 8, at 295 (reviewing research on determinants of out-of-pocket expenditures and noting that “[p]revious research consistently reported a positive relationship between out-of-pocket expenses and household income”).

22. See generally Daniel Feenberg & Jonathan Skinner, *The Risk and Duration of Catastrophic Health Care Expenditures*, 76 REV. ECON. & STAT. 633, 645–646 (1994) (finding that lower income households spent a greater proportion of their limited incomes on medical expenses than did higher income households, and suggesting that this explains why wealthier families opposed tax burdens associated with catastrophic health care legislation); Alison A. Galbraith et al., *Out-of-Pocket Financial Burden for Low-Income Families With Children: Socioeconomic Disparities and Effects of Insurance*, 40 HEALTH SERVS. RES. 1722, 1722 (2005).

23. See, e.g., Waters et al., *supra* note 8, at 345.

24. See Banthin & Bernard, *supra* note 20, at 2715; Galbraith et al., *supra* note 22, at 1729 (finding that only 15% of families had out-of-pocket expenditures greater than 10% of their income). For an analysis of data from the 1970s also finding a relatively small percentage of households with out-of-pocket expenses exceeding certain thresholds, see Wyszewianski, *Families With Catastrophic Health Care Expenditures*, *supra* note 8, at 621–22 (finding that 80% of families had out-of-pocket expenditures less than 5% of income, only 4.2% of families had out-of-pocket expenses exceeding 20% of income, and two-thirds of the families with greater

households, these data suggest that the likelihood of a truly catastrophic health expenditure is low,²⁵ particularly for those without multiple chronic conditions.²⁶

As we move from discussing medical expenses to medical debt, we see that delinquency in payment of small out-of-pocket medical bills is fairly common.²⁷ Medical debt is among the notations on credit reports that debt collectors make most.²⁸ In a nationally representative sample of credit reporting data from 1999 analyzed by Federal Reserve researchers, more than one-third (36.5%) of medical bills reported by collection agencies were for \$100 or less, 70% were for \$250 or less, and the median bill was \$142.²⁹ Only 4.2% of the court judgments in the files that could be identified as medical in origin were for \$5,000 or more.³⁰ And only 11.5% of the medical debts precipitating collection agency activity were reported as having been paid off.³¹

Other kinds of studies illustrate the ubiquity of medical debt delinquency even though the bills may be non-catastrophic. In the nationally representative

than 20% expenditures were below the poverty level). Wyszewianski notes that “most of the families incurred catastrophic expenditures not so much because the amounts involved were very large, but because their incomes were relatively low and their health coverage was less adequate.” *Id.* at 624 (emphasis omitted); see also CONG. BUDGET OFF., *supra* note 13, at xiv–xv (using Blue Cross Federal Employee plan data from the mid-1970s, and finding that most expenses were concentrated among a small percentage of patients).

25. See Schoen et al., *supra* note 8, at W5-293 (reporting much higher rates of underinsurance among lower income households). The Schoen findings were that about 7% of continuously insured individuals had out-of-pocket expenses representing 10% or more of income (or 11% if certain low-income adults were added), and 3% faced deductibles that were 5% or more of income. *See id.*

26. See Waters et al., *supra* note 8, at 347; Wenke Hwang et al., *Out-of-Pocket Medical Spending for Care of Chronic Conditions*, HEALTH AFF., Nov.-Dec. 2001, at 267, 270 (finding “a positive, nearly linear relationship between out-of-pocket medical spending and number of chronic conditions” and finding that the relationship “mostly persisted when the population was grouped by socioeconomic and demographic characteristics”).

27. This is in addition to the possibility that a larger group of people are exposed to high expenses when the time period is extended longer than a year. See CONG. BUDGET OFF., *supra* note 13, at xiv–xvi.

28. See Robert B. Avery et al., *An Overview of Consumer Data and Credit Reporting*, FED. RES. BULL., Feb. 2003, at 47, 69, available at <http://www.federalreserve.gov/pubs/bulletin/2003/0203lead.pdf>.

29. *See id.*; see also Robert W. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 51 ST. LOUIS U. L.J. 325, 338 (2007) (reporting that one-third of respondents who had medical debt on their credit report had debts under \$1,000, and 16% had debts under \$500).

30. See Avery et al., *supra* note 28, at 67. The percentage is skewed downward by the fact that nearly one-fifth (18.4%) of the medical debt court judgments were either paid or dismissed, and thus were listed as zero dollars. *See id.*

31. *See id.* at 69. One might question whether collectors have the incentive to consistently report payoff information.

Community Tracking Study Household Survey conducted by the Center for Studying Health System Change, the bulk of people with medical bill problems had bills of \$2,000 or less.³² In a joint telephone survey of the Kaiser Family Foundation, the Harvard School of Public Health, and USA Today, nearly one-quarter of people reported having problems paying medical bills in the past year, more than one in five Americans reported an overdue medical bill, and almost two in ten reported serious financial consequences from medical bills in the past five years.³³ In a single-site study of credit counseling participants in a relatively wealthy county, nearly 30% of the participating households reported a troublesome medical bill.³⁴

This brief review suggests that we should try to speak with precision when discussing the medical debt problems that households face. People with chronically low incomes are particularly vulnerable to receiving medical bills that consume huge proportions of their income, and this presents a special policy problem, particularly to the extent that fear of medical bills deters the consumption of necessary health care.³⁵ With respect to the non-poor, non-elderly population, a small number of people have truly catastrophic out-of-pocket medical expenses in any given year. The issue (and risk) facing most American households is distinct from these two. Surprising proportions of American households have ongoing debtor-creditor relationships stemming from medical bills of much more modest size, both in an absolute sense and as a proportion of income.

32. See Jessica H. May & Peter J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, ISSUE BRIEF (Ctr. for Studying Health Sys. Change, Washington, D.C.), June 2004, at 2, available at <http://www.hschange.com/CONTENT/689/689.pdf>. Thirty-four percent of families with out-of-pocket costs of more than \$2,000 reported medical bill problems, but the majority of people had lower out-of-pocket expenses. *Id.*

33. See USA TODAY, KAISER FAM. FOUND. & HARVARD SCH. OF PUB. HEALTH, HEALTH CARE COSTS SURVEY: SUMMARY AND CHARTPACK (Aug. 2005), available at <http://www.kff.org/newsmedia/upload/7371.pdf>; Henry J. Kaiser Family Foundation, *supra* note 1, at 1; see also Michelle Doty et al., *Seeing Red: Americans Driven Into Debt By Medical Bills*, ISSUE BRIEF (Commonwealth Fund, New York, N.Y.), Aug. 2005, at 1, available at http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf (reporting that 14% of adults had medical debt).

34. See Deborah Gurewich et al., *Medical Debt and Consumer Credit Counseling Services*, 15 J. HEALTH CARE FOR THE POOR & UNDERSERVED 336, 339 (2004).

35. See, e.g., Robert W. Seifert & Mark Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, HEALTH AFF., Feb. 28, 2006, at W89, W90 (referring to studies of medical debt among specific populations, including targeted studies of low-income people).

B. Bankruptcy Filers With Medical Debt

This subpart focuses on studies of medical debts of bankruptcy filers.³⁶ To be clear, these are findings relating only to actual direct medical debt, not indirect costs of illness or injury. The findings are relatively consistent with the suggestion in Part I.A. that several debtor-patient paradigms are emerging.

1. The Department of Justice

The Executive Office for United States Trustees (EOUST), part of the United States Department of Justice (DOJ), retains a large sample of case information from no-asset chapter 7 cases from all but two states.³⁷ At the request of Senator Charles Grassley, William Moschella, an Assistant Attorney General in the U.S. Department of Justice, reported on a review of 5,203 no-asset chapter 7 cases closed between 2000 and 2002.³⁸ Moschella reported that Schedule F (a required document listing debts in each case) had been reviewed for the presence of medical debts: “This would include where the creditor was a doctor, hospital or other treatment facility, medical collection agency, or if the debt was in any way identifiable as being medical in origin.”³⁹

Based on this method, Moschella reported that medical debt was listed in 46% of the cases.⁴⁰ Of the cases listing medical debt, the average medical debt was slightly under \$5,000 per case.⁴¹ Among all of the cases, 1% of the cases accounted for 36.5% of the debt, and less than 10% of the cases accounted for 80% of the medical debt.⁴² Focusing on only those cases reporting medical debts, about one-fifth (21.6%) of the filers held four-fifths (80.9%) of all the medical debt listed.⁴³

Researchers associated with the EOUST had used a similar methodology to review nearly 2,000 cases closed in 2000.⁴⁴ In that sample, about 46% had medical debt listed on Schedule F, and 11.1% of debtors reported \$5,000 or

36. For a retrospective literature review, see Melissa B. Jacoby et al., *Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 378–382 (2001).

37. The two states are North Carolina and Alabama because courts in those states do not participate in the United States Trustee Program.

38. See 151 CONG. REC. S2053, 2078 (daily ed. Mar. 4, 2005) (reprinting a letter to Senator Charles E. Grassley from William E. Moschella).

39. *Id.*

40. *Id.*

41. *Id.* (reporting a \$4,978 per case average).

42. See *id.*

43. 151 CONG. REC. S2053, 2078 (daily ed. Mar. 4, 2005) (reprinting a letter to Senator Charles E. Grassley from William E. Moschella).

44. Ed Flynn & Gordon Bermant, *The Class of 2000*, 2001 AM. BANKR. INST. J. 20, 20 (2001). It is unclear from their report what means Flynn and Bermant used to identify medical debt on Schedule F. Bermant and Flynn note in their report that the Schedule F data did not capture any medical debt that has been financed with consumer credit. *Id.* at 20 n.2.

more in medical debts.⁴⁵ In 4.4% of the cases, medical debt comprised one half or more of total unsecured debt.⁴⁶ The researchers noted:

[T]he medical-debt figures were highly skewed by a few debtors with enormous medical debts. Our sample included 14 debtors with more than \$50,000 in medical debts, including one debtor who listed \$615,000 in medical debts. Although these debtors constituted less than one percent of our sample, they accounted for more than one-third of the total medical debt reported.⁴⁷

Many researchers (myself included) believe that Schedule F is a significantly underinclusive measure of medical debt.⁴⁸ Nonetheless, the Schedule F data collected by the DOJ and EOUST underscore a more generalizable point: a small number of cases involve medical bills that would be considered catastrophic under any definition.⁴⁹ Many more filers are struggling with medical debt as part of a broader set of financial problems, including, perhaps, indirect costs of illness or injury such as income loss.⁵⁰

2. Mathur

In an American Enterprise Institute working paper, Aparna Mathur evaluated data from the Panel Study of Income Dynamics (PSID), a major longitudinal dataset.⁵¹ Mathur described her project as the “first paper to use longitudinal household data to identify the impact of medical bills (and other health related factors) on bankruptcy.”⁵² The bankruptcy filers in the PSID were asked their reasons for filing for bankruptcy, but Mathur did not use these as the basis of her study.⁵³ Instead, she focused on the reports about their debts and the reasons for incurring those debts.⁵⁴ The PSID asked respondents about household loans and the reasons for taking them (most important, secondary or

45. *Id.* at 20.

46. *Id.*

47. *Id.* at 20–21.

48. See 151 CONG. REC. S5945, 6010 (daily ed. May 26, 2005) (reprinting a letter to Senator Charles E. Grassley from David Himmelstein et al., dated Feb. 14, 2005, which lists the ways in which Schedule F excludes medical debt).

49. See Flynn & Bermant, *supra* note 44.

50. See *infra* Part II.A.

51. See Mathur, *supra* note 4, at 7 (describing PSID). The PSID is supposed to be nationally representative, but it underrepresents bankruptcy filers by half. See *id.* In addition to questions of whether the filers in the study are somehow more stable or well-off than bankruptcy filers as a whole, this results in a relatively small number of filers to analyze (74). *Id.* Nonetheless, this study represents an important piece of the medical debt puzzle.

52. *Id.* at 5.

53. *Id.* at 7–8. For example, Mathur reports that 9% of the filers in the PSID sample reported that medical bills were their primary reason for filing, with another 6% reporting illness or injury. *Id.* at 8. Even putting these two together, they produce a much lower figure than the 1999 and 2001 Consumer Bankruptcy Project survey findings. See *infra* Part I.B.3.

54. See Mathur, *supra* note 4, at 8, 9.

tertiary reasons).⁵⁵ Thus, unlike the Schedule F method, Mathur's method should have captured some debts that otherwise would not be recognizable as medical.

Mathur concluded that medical debts are significantly related to bankruptcy filings but that they are not the "leading cause" of bankruptcy.⁵⁶ Yet, Mathur found that "medical debts are primarily responsible for 27 percent of all bankruptcy filings."⁵⁷ By this, she referred only to cases in which financing medical obligations represent the primary purpose of the debt.⁵⁸ She also reported on various approaches for determining the marginal impact of increase in medical debts on the probability of filing for bankruptcy.⁵⁹

Finding over a quarter of filers with *primarily* medical debts is indeed striking (and reinforces concerns about relying on Schedule F data). Note, however that there are sure to be other filers in the sample who have medical debt that is not the primary debt, as well as other kinds of medical-related financial consequences.⁶⁰ Thus, the Mathur analysis again suggests the existence of multiple debtor-patient paradigms, albeit in a different proportion than some of the other studies.

3. Consumer Bankruptcy Project

Over time, the Consumer Bankruptcy Project (CBP) has evolved in its methods of measuring the presence of certain kinds of debt and financial problems, including those stemming from illness or injury.⁶¹ In their study of people who filed for bankruptcy in 1981, Sullivan, Warren, and Westbrook used court records from ten federal districts.⁶² From those court records, they found that over half of the debtors listed medical debt in their files, that medical debt accounted for about 11% of unsecured debt, and that there was enormous variation in the amount of debt per case and in the percentage of total unsecured debt per case.⁶³ The researchers estimated that "at most only 1% to 2% of the debtors in bankruptcy are demonstrably there because of

55. *Id.* at 8.

56. *Id.* at 5, 26.

57. *Id.* at 21.

58. *Id.* at 5.

59. See Mathur, *supra* note 4, at 15–18. Mathur's results should be compared to those of Ian Domowitz and Robert Sartain, who found that medical debt had the greatest impact of any household condition in raising the probability of bankruptcy, and that high medical debt alone could be responsible for approximately 30% of the cases in 1994. See Ian Domowitz & Robert L. Sartain, *Determinants of the Consumer Bankruptcy Decision*, 54 J. FIN. 403, 413 (1999). The researchers used a qualitative choice model based on bankruptcy case data from 1980. *Id.* at 403.

60. See Mathur, *supra* note 4.

61. For the earliest book-length report, see TERESA A. SULLIVAN ET AL., AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA 17–20 (1989).

62. *Id.*

63. See *id.* at 168, 173.

catastrophic medical losses,”⁶⁴ but they went on to note that “[m]ore modest medical debts are typical.”⁶⁵ Yet, they recognized that reliance exclusively on the court records might be resulting in a significant undercount of medical debt.⁶⁶ Based on these undercounting concerns, later phases of the CBP employed different methods.⁶⁷ In 1991, Sullivan, Warren, and Westbrook did not specifically solicit or collect medical debt data, but instead interpreted responses to an open-ended question about reasons for filing for bankruptcy.⁶⁸

In 1999 and 2001, CBP researchers turned to other methods of medical debt identification.⁶⁹ In the 1999 study, the written survey instrument asked filers to indicate if they owed money to various creditors, including “Health Care Providers, Services, Supplies,” in response to which 31% reported that they had this kind of bill.⁷⁰ Filers also were asked whether they had owed medical debts not covered by insurance in excess of \$1,000 during the prior two years, regardless of how the bills were financed or whether they were still unpaid at the time of bankruptcy.⁷¹ One-third (33.8%) reported that they did.⁷²

In 2001, CBP researchers combined the \$1,000 threshold question on the written survey instrument with follow-up telephone interviews that probed more deeply into out-of-pocket costs.⁷³ In the written questionnaire group, 27% reported that they had medical bills uncovered by insurance exceeding \$1,000 in the prior two years.⁷⁴ Among the follow-up telephone interviews with debtors who said they had medical reasons for bankruptcy, the average amount of out-of-pocket medical expenses (excluding premiums) was over \$3,500 in the year leading up to bankruptcy.⁷⁵ This figure does not include insurance premiums, which averaged \$734 for those who had continuous insurance.⁷⁶ The average out-of-pocket expenditure since illness onset was nearly \$12,000.⁷⁷ The averages varied when the researchers broke down the

64. *Id.* at 168.

65. *Id.* at 169.

66. SULLIVAN ET AL., *supra* note 61, at 17–20.

67. *See* TERESA A. SULLIVAN ET AL., *THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT* 269–70 (2000).

68. The researchers used an open-ended question about reasons for bankruptcy, which in turn produced some responses related to medical-related financial distress. *See id.* at 7, 269–70. Only 5.7% specified medical debts as a reason for bankruptcy, while a total of 19.3% reported some sort of medical reason, of which medical debt might have been a part. *Id.* at 145.

69. *See* Himmelstein et al., *supra* note 6, at W5-63; Jacoby et al., *supra* note 36.

70. Jacoby et al., *supra* note 36, at 387.

71. *Id.* at 389.

72. *See id.*

73. *See* Himmelstein et al., *supra* note 6, at W5-65, W5-70.

74. *Id.* at W5-67.

75. *Id.* at W5-69 (reporting \$3,686 as the average out-of-pocket costs).

76. *Id.*

77. *Id.* (reporting an \$11,854 average, and reporting confidence interval).

respondents by diagnosis and type and continuity of insurance coverage.⁷⁸ The highest average-cost diagnosis was cancer, producing a mean out-of-pocket expenditure of over \$35,000 since illness onset.⁷⁹

The CBP researchers did not report on filers' medical debts in terms of percentage of individual income, but David Himmelstein and his coauthors noted that "[d]ebtors' out-of-pocket medical costs were often below levels that are commonly labeled catastrophic."⁸⁰ In addition, like the other studies reviewed in this subpart, the CBP researchers did not report how the numbers might have changed had the small number of elderly been separately analyzed, as is often done in non-bankruptcy studies.⁸¹ Yet, in general, the CBP data support the existence of multiple debtor-patient paradigms, as opposed to a model of widespread bankrupting by medical debt alone.⁸² Buried within the averages are a small number of filers with catastrophic medical debts and a much larger number of filers with some medical debt coupled with other financial consequences—from sickness and otherwise.

II. OTHER DIMENSIONS OF MEDICAL-RELATED FINANCIAL DISTRESS

A. *Indirect Costs of Illness*

Sickness contributes to financial distress through lost work even if out-of-pocket expenses are modest.⁸³ In bankruptcy studies, job problems and medical problems were closely correlated, raising questions about the ways these two issues could be linked.⁸⁴ In response to direct questioning, 20% of the sample in the 2001 CBP study indicated medical problems as a reason they had lost two or more weeks of work.⁸⁵ In follow-up telephone interviews, the majority of filers who indicated a medical reason for filing said that medical-related lost income troubles played a large role.⁸⁶ Disability insurance coverage was rare.⁸⁷ A study of credit counseling participants similarly found

78. See Himmelstein et al., *supra* note 6, at W5-70.

79. See *id.* (reporting a \$35,878 average).

80. *Id.* at W5-69.

81. See *id.*

82. See Himmelstein et al., *supra* note 6; Jacoby et al., *supra* note 36.

83. See Jacoby et al., *supra* note 36, at 407–09.

84. *Id.* (reporting on the 1999 study and the 1991 study). See generally Feenberg & Skinner, *supra* note 22, at 644 (“A more general model of health status and medical expenses would include the joint determination of medical spending and income. Costly illness may precipitate early retirement, or depletion of existing assets for medical expenses could then reduce subsequent income.”).

85. Himmelstein et al., *supra* note 6, at W5-67.

86. See Jacoby & Warren, *supra* note 2, at 561 (reporting that 71.6% said income troubles contributed “very much” and another 8.6% said they contributed “somewhat”).

87. *Id.* at 562 (reporting that only 21.2% of people said their employer offered them long-term disability insurance, and only 15% had some form of long-term disability insurance).

people struggling with medical-related income problems regardless of whether they had large medical debts.⁸⁸

Medical-related income problems may vary depending on who in the household got sick and how the sickness affected work abilities.⁸⁹ They also may vary between the duration and severity of the illness.⁹⁰ To flesh out this picture, Table 1 reports common diagnoses of the participants in the CBP study, including many chronic problems. Many of these diagnoses may continue to contribute to financial insecurity through a variety of direct and indirect channels, including but not limited to medical debts.

Type of Disorder/Disease	% Citing as Primary or Secondary Diagnosis
Cardiovascular	26.6%
Trauma and Orthopedic (other than back, spine)	17.1%
Mental	14.6%
Back and Spine	13.8%
Pulmonary	13.5%
Diabetes	11.2%
Other	10.2%
Cancer	9.5%
Maternal, Perinatal, Congenital	9.2%
Neurologic	5.9%
Rheumatologic	4.9%
Gastrointestinal	4.9%
Infectious Disease	4.7%
Death	14.1%

Although income loss is an obvious indirect cost, it is not the only example. Households incur costs adjusting to illnesses or disabilities, such as the cost of acquiring vans to hold wheelchairs or extra transportation expenses

88. See Gurewich et al., *supra* note 34, at 339. “We also found, like studies examining the association between medical problems and bankruptcy, that income-related effects stemming from a medical problem (e.g., not being able to work or sustain the same level of work as before the medical problem occurred) are the most common consequences of a medical problem.” *Id.*

89. Jacoby & Warren, *supra* note 2, at 562–63.

90. *Id.*

91. N=391. These results are summarized in Himmelstein et al., *supra* note 6, at W5-67. It should be noted that some of these conditions are also associated with higher direct medical spending. See Banthin & Bernard, *supra* note 20, at 2717.

associated with frequent trips to medical facilities.⁹² People also incur what might be called “consolation costs”: the exhaustion from fighting a disease and the bureaucracy associated with insurers and providers may contribute to enhanced consumption. Other significant opportunity costs may flow from illness or injury in ways not captured in most U.S. health care finance discussions.⁹³ For example, if an individual has a chronic illness, her partner, relatives, or children may alter their paths, such as deferring or cancelling plans to pursue higher education or vocational training, with long-term productivity losses and related financial ramifications.⁹⁴ Indirect financial costs associated with illness or injury help explain the destabilization of some households with modest medical debts.

B. Failed Coping Mechanisms⁹⁵

An individual encountering some kinds of financial problems often has no way to know how long the problems will last or where they will lead. After the fact, the optimal point for selling a house or making another large financial adjustment may seem apparent. In the throes of the situation, however, it will be unclear if a mother will find a new job quickly, whether a father’s recovery from a serious accident will take weeks or months, or whether spouses will reconcile after a separation. Some popular coping strategies that individuals have used to get through times of financial uncertainty can exacerbate the ultimate financial trouble that otherwise would be caused by non-catastrophic medical expenses. I note two here.

1. Consumer Credit

Consumer credit has become the *de facto* umbrella insurance policy for individuals and families hovering on the edge of financial stability.⁹⁶ Observers critical of the availability of bankruptcy sometimes have been quick to regard the debt burden of bankruptcy filers as evidence of willingness to spend beyond their means. Surely some bankruptcy filers fit that

92. For an attempt to get a handle on the magnitude of costs other than direct medical costs, see, for example, Eric J. Sherman et al., *The Collection of Indirect and Nonmedical Direct Costs (COIN) Form: A New Tool for Collecting the Invisible Costs of Androgen Independent Prostate Carcinoma*, 91 *CANCER* 841 (2001) (tracking expenses such as transportation, parking, and the cost of various family members’ time associated with treatment).

93. See, e.g., R. Sauerborn et al., *Household Strategies to Cope With the Economic Costs of Illness*, 43 *SOC. SCI. & MED.* 291 (1996).

94. See generally S.E. Berki, *A Look at Catastrophic Medical Expenses and the Poor*, *HEALTH AFF.*, Winter 1986, at 138, 138 (noting productivity losses from disease).

95. This subpart is derived from Melissa B. Jacoby, *Identifying and Managing Household Risk: Lessons From Bankruptcy* (Oct. 20, 2005), <http://privatizationofrisk.src.org/Jacoby/>.

96. See Melissa B. Jacoby, *Generosity Versus Accessibility: Bankruptcy, Consumer Credit, and Health Care Finance in the US*, in *CONSUMER BANKRUPTCY IN GLOBAL PERSPECTIVE* 286 (Johanna Niemi-Kiesiläinen, Iain Ramsay & William Whitford eds., 2003).

characterization, although their bankruptcy relief may be limited or denied if their circumstances attract the attention of courts or trustees.⁹⁷ Yet, it is equally if not more plausible to posit that a high debt burden develops in part from an attempt to avoid financial defeat and bankruptcy. Families rely on consumer credit to fill gaps in the budget or to pay medical bills.⁹⁸ They hope and believe that they will repay in full once the new job is found, the medical crisis is over, or whatever other trouble has passed.

The desirability of smoothing medical care consumption is giving rise to discrete credit products. Some lenders are offering medical-specific credit cards, while hospitals might direct patients to a particular bank to finance the self-pay portion of an expensive medical procedure.⁹⁹ Debit cards associated with health savings accounts and high-deductible health plans may increasingly include credit extension opportunities to cover out-of-pocket liabilities that exceed the account balance.

The provision of general-purpose or medical-specific credit is not a free service, of course. To the extent that the terms of this credit are based on credit scores, the credit will be even more costly for people already in or heading toward financial trouble. Thus, using credit to smooth consumption of medical care and other health maximizing goods and services is understandable and potentially desirable, but can contribute to financial instability in the long run. In so doing, it may magnify the impact of a medical bill that originally was of modest size.

2. Self-Rationing

Whether or not they sought new financing, households with modest medical debts also may have tried to avert financial disaster through drastic reductions in new spending. In trying to adjust to a crisis of unknown duration and severity, some financially-strapped families avoid spending money they do not have by canceling or delaying doctors' appointments, letting prescriptions go unfilled, buying less food, and delaying payment on insurance premiums.¹⁰⁰ By trying to stem the growth of their liabilities in the short-term, however,

97. See *Zolg v. Kelly III (In re Kelly III)*, 841 F.2d 908, 913–15 (9th Cir. 1988) (making the debtor's ability to pay debts as they become due the primary consideration for whether Chapter 7 discharge would be substantial abuse of bankruptcy system); Melissa B. Jacoby, *Ripple or Revolution? The Indeterminacy of Statutory Bankruptcy Reform*, 79 AM. BANKR. L.J. 169, 171–72 (2005).

98. See, e.g., SARA R. COLLINS ET AL., COMMONWEALTH FUND, THE AFFORDABILITY CRISIS IN U.S. HEALTH CARE: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY 1, 18 (Mar. 2004) (collecting data on use of credit for medical bills), available at http://www.cmwf.org/usr_doc/collins_biennial2003_723.pdf.

99. For a list of medical-specific credit products and receivables arrangements with providers, see Jacoby & Warren, *supra* note 2, at 559–60.

100. See, e.g., Himmelstein et al., *supra* note 6, at W5-68.

families may increase their risk of significant financial trouble in the long-term that far exceeds their medical bills.

C. *Financial Volatility Overall*

Notwithstanding the supplementary accounts provided in Parts II.A. and II.B., it remains troubling that many households have difficulty absorbing relatively common levels of out-of-pocket medical expenses. Perhaps some might have better prepared for the possibility of economic hardship.¹⁰¹ After all, even if the health care finance system is restructured in a significant way, health care is not going to be free for middle-income households; whether through taxes, lower wages, out-of-pocket payments, or some other means, all but perhaps the poorest households will bear significant financial responsibility for health care, just like we do for other necessary expenses. Thus, research taking a closer look at the stability of household finances becomes relevant to the question of why medical bills seem to be posing problems for many households.

Mark Rank and Thomas Hirschl have used PSID data to examine the extent to which Americans experience financial extremes in income.¹⁰² They found that by age seventy-five, over half of all Americans will have lived at least one year in poverty,¹⁰³ over half will have experienced affluence,¹⁰⁴ and the chances of experiencing one extreme or another are about fifty-fifty.¹⁰⁵ Also using PSID data, Jacob Hacker has found that the probability of experiencing a drop in family income of 20% or more has more than doubled in the last generation.¹⁰⁶

101. See Melissa B. Jacoby, *The Debtor-Patient: The Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 459–60 (2004).

102. See Mark R. Rank & Thomas A. Hirschl, *Rags or Riches? Estimating the Probabilities of Poverty and Affluence Across the Adult American Life Span*, 82 SOC. SCI. Q. 651, 666–67 (2001).

103. *Id.* at 666. In an earlier study, Rank and Hirschl found that two-thirds would fall below the federal poverty line by the age of eighty-five. See Mark R. Rank & Thomas A. Hirschl, *The Likelihood of Poverty Across the American Adult Life Span*, 44 SOC. WORK 201, 205 (1999).

104. Rank & Hirschl, *supra* note 102, at 666.

105. *Id.* at 667. The odds are not evenly distributed among racial groups and those with various levels of education, however. See *id.* at 661, 667.

106. Jacob S. Hacker, *The Privatization of Risk and the Growing Economic Insecurity of Americans* (Feb. 14, 2006), <http://privatizationofrisk.ssrc.org/Hacker/> (reporting on research with Nigar Nargis) [hereinafter Hacker, *Privatization of Risk*]; see also Jacob S. Hacker, *Middle-Class Tightrope: It's More Dire Than the Numbers Show*, WASH. POST, Aug. 10, 2004, at A19 (reporting that family incomes are becoming unstable). This has led Hacker to refer to a “family risk factor” in various publications. See Jacob S. Hacker, Op-Ed, *Call it the Family Risk Factor*, N.Y. TIMES, Jan. 11, 2004, at 15; Jacob S. Hacker, *False Positive*, NEW REPUBLIC, Aug. 16, 2004, at 14. Hacker’s ideas on this point are set forth in more detail in his new book, JACOB S. HACKER, *THE GREAT RISK SHIFT: THE ASSAULT ON AMERICAN JOBS, FAMILIES, HEALTH CARE, AND RETIREMENT AND HOW YOU CAN FIGHT BACK* (2006). Hacker attributes the rising volatility

As a related matter, Rank and Hirschl have studied participation in means tested welfare programs.¹⁰⁷ Again using PSID data, they found that about two-thirds of Americans will have participated in means-tested welfare programs between the ages of twenty-five and sixty-five.¹⁰⁸ Rank and Hirschl conclude that “a social safety net is applicable not only to disenfranchised individuals in society, but to the majority of Americans.”¹⁰⁹

Filling in the other side of the family budget equation is research finding high fixed expenses that leave little margin for error. Using government data on household expenditures, Elizabeth Warren and Amelia Tyagi have reported that American families spend a much larger share of income on housing, health care, child care, and transportation than before the two-income family had become so prevalent.¹¹⁰ Households are correspondingly less able to handle the income shocks or unexpected expenses when they arise.¹¹¹

These studies do not speak directly to the question of whether medical bills are a trigger for a spiral downward or the consequence of an existing financial problem. But they suggest a level of financial vulnerability among a larger proportion of the population, which may help contextualize the trouble paying medical bills that many American households report.¹¹²

CONCLUSION

To contribute to this symposium, I have used data on medical expenses and medical debt to isolate multiple debtor-patient paradigms. Medical debt and delinquency are surprisingly widespread but often not catastrophic and may be

to “the complex interaction of two profound changes in the economic environment of middle-class families: rising job instability and the transformation of the American family.” Hacker, *Privatization of Risk*, *supra*.

107. See Mark R. Rank & Thomas A. Hirschl, *Welfare Use as a Life Course Event: Toward a New Understanding of the U.S. Safety Net*, 47 SOC. WORK 237 (2002).

108. See *id.* at 241. This includes both in-kind programs and cash programs. See *id.* Medicaid and food stamps have “the farthest reach.” *Id.* at 243. For a later publication reporting that slightly over half of the population will use food stamps alone between the ages of twenty and sixty-five, see Mark R. Rank & Thomas A. Hirschl, *Likelihood of Using Food Stamps During the Adult Years*, 37 J. NUTRITION EDUC. & BEHAV. 137, 141 (2005). As with income levels, the likelihood of food stamp usage varies by race and education. See *id.* at 142.

109. Rank & Hirschl, *supra* note 107, at 246. The authors note that their findings “underscore the existence of economic vulnerability in the United States” and indicate that welfare usage should be treated as a life course event. *Id.* at 245.

110. See ELIZABETH WARREN & AMELIA WARREN TYAGI, THE TWO-INCOME TRAP: WHY MIDDLE-CLASS MOTHERS AND FATHERS ARE GOING BROKE 49–54 (2004); see also Elizabeth Warren, *Rewriting the Rules: Money, Family and Risk*, fig. 2 (Oct. 21, 2005), <http://privatizationofrisk.ssrc.org/Warren/>.

111. See WARREN & TYAGI, *supra* note 110, at 53–54; see also Warren, *supra* note 110.

112. See generally David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 704–14 (2004) (discussing middle income attitudes toward lower income people and government programs).

incurred in a broader context of financial vulnerability. Recognizing that medical debt problems are not monolithic has implications not only for health care finance, but for proposals to increase the legal regulation of medical debt and debt collection practices of medical providers. Some recent medical debt proposals would restrict the type of collection activities in which hospitals may engage,¹¹³ while others would prohibit medical providers from reporting such information altogether under certain circumstances.¹¹⁴

Proposed restrictions on medical debt collection seem to be based on a catastrophic model of medical debt—that the debts are involuntary and inherently unpayable, making efforts to collect inefficient and unfair. A prevalent non-catastrophic medical debt paradigm may undercut efficiency and fairness explanations for such proposals. If it is the case that the most common medical debts do not differ significantly in magnitude from debts arising from other necessities that result in debt on credit reports, such as utilities, shelter, food, and clothing, the justification for a legal distinction in collection practices becomes less obvious, particularly if the medical bills are arising from routine care. Restrictions on medical debt collection also should raise some moral hazard concerns. Even if it is true that most people want to pay their medical bills, financially stressed households must make choices each and every day about how to prioritize their expenses and allocate scarce resources. Reducing the consequences of non-payment of non-catastrophic medical debt for non-poor households could move medical providers even further down the priority list than they are today, leaving providers trying to adjust to greater shortfalls through, say, altering services or reducing charity care.¹¹⁵ Credit reporting and collection restrictions also may lead some medical providers to press harder to receive up-front payment from patients, probably in the form of third party credit to which some of the proposed restrictions will not apply. To

113. For an overview of the proposals, see Jacoby & Warren, *supra* note 2, at 540–41.

114. See, e.g., Medical Bills Interest Rate Relief Act, H.R. 1238, 109th Cong. § 4 (2005). The Medical Bills Interest Rate Relief Act also would require that credit card lenders freeze the interest rates of a borrower who informs the credit card lender of the medical expense. *Id.* § 3. Additionally, Robert Seifert argues:

Given the atypical nature of medical debt and the commonly expressed policy to treat it differently, one might question the need for health care providers to report these debts to credit bureaus at all. Lenders, creditors, credit bureaus, and regulators should consider ways to prevent medical debt from ever tarnishing a credit record, including rules to prohibit medical providers and their agents from reporting medical debt to credit agencies. Seifert, *supra* note 29, at 346. For another perspective, see CAROL PRYOR & JEFFREY PROTTAS, ACCESS PROJECT, PLAYING BY THE RULES BUT LOSING: HOW MEDICAL DEBT THREATENS KANSANS' HEALTHCARE ACCESS AND FINANCIAL SECURITY 1, 24–25 (Jan. 2006), available at www.accessproject.org/adobe/kansas_playing_by_the_rules.pdf.

115. See Colombo, *supra* note 3, at 453–55 (referring to impact of Minnesota agreements to give favored billing treatment to even higher income uninsured individuals who might choose not to get insurance).

the extent that these concerns do not overcome the enthusiasm for restricting medical debt collection, law- and policy-makers should at least consider encouraging or requiring a broader range of medical debt credit reporting so that debtor-patients get credit for their payments and not just debits for their delinquency.¹¹⁶

Going forward, discussion of medical debt—whether to inform health care finance policy, debtor-creditor policy, or some other objective—should recognize that medical debts can contribute to financial distress in multiple ways, but it is not productive to assume that they are always the standalone trigger.

116. See Seifert, *supra* note 29, at 343 (“Unlike many other types of debt, medical debt usually can only harm a credit rating, not help it. When medical providers and their collection agents report debt to credit bureaus, they typically do so only when payments have not been made.”).