

Managing Medical Bills on the Brink of Bankruptcy

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*This paper presents original empirical evidence on financial interactions between medical providers and their patients who go bankrupt. We use a nationally representative sample of people who filed for bankruptcy in 2007 to compare two popular but hotly contested methods of measuring medical burden. By applying both methods to the same filers, we find that nearly four out of five respondents had some financial obligation for medical care not covered by insurance in the two years prior to filing, but only about half of the court records contain identifiable medical debt, and of substantially more modest amounts. We test several theories to explain the discrepancy and find we can explain it to a significant extent by filers' methods of managing medical bills that make many bills undetectable using the court record method. For example, we find the highest rates of mortgage and credit card use for medical bills among respondents with the largest discrepancies between the two measures. Respondents who specifically report medical bills as a reason they filed for bankruptcy mortgaged their homes for medical bills at nearly four times the frequency of other filers, and were about a third more likely to use credit cards for medical bills. We also find disparities by age, sex, race, and housing tenure that skew the court record measure. Our findings offer a window into the success of medical practice management in reducing providers' financial exposure from patient liabilities. However, one implication of this "success" is that the popular court record method of measuring medical bills should not be used on a standalone basis to measure the impact of medical bills on financially distressed families. The court record method also should not be used to refute survey estimates of medical burden.*

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Medical men who frequently go to law to recover fees generally lose more in the end than they gain; not only because such attempts to recover often prove fruitless, but because they excite prejudice and make influential enemies.  
D.W. CATHELL, THE PHYSICIAN HIMSELF FROM GRADUATION TO OLD AGE 292 (1925)

## I: Introduction

In the vast majority of health care interactions, patients in the United States bear some direct financial liability to medical providers regardless of insurance status.<sup>1</sup> Whether they are not-for-profit hospitals or for-profit small businesses, health care providers cannot be indifferent to the collection of these self-pay obligations. Consultants in medical practice management have developed and marketed extensive advice for structuring all aspects of providers' interactions with patients to mimic commercial transactions in other retail service contexts.<sup>2</sup> This advice, if successful, shields providers from the public scrutiny of after-the-fact debt collection, such as through law suits and liens.<sup>3</sup>

The ways in which providers systematically seek to reduce or avoid remaining creditors of their patients affect the study of the financial burden of health care. In recent years, lawmakers and scholars have debated whether medical problems play a significant role in fueling personal bankruptcy filings. This politically- and ideologically-charged question has been closely linked with a methodological dispute. Some scholars measure medical-related bankruptcy using survey techniques. Skeptics of survey-based findings often cite, in refutation, studies of bankruptcy court records. The court record method entails looking for creditors with medical identities in the documents that bankruptcy filers submit to the court.

A very public example of a clash over these methods arose directly prior to the passage of the Bankruptcy Abuse and Consumer Protection Act of 2005, the most significant set of amendments to the Bankruptcy Code in a generation. To challenge a survey study finding a high rate of medical-related bankruptcy, senators who supported the bill, which substantially restricted debt relief, cited a court record analysis conducted by the Department of Justice.<sup>4</sup> In the DOJ analysis, only 5.5% of total unsecured debt of the sample was demonstrably medical debt. No medical debt could be found in over half of the sample, and the average medical debt among those with any such debt was under \$5,000.<sup>5</sup>

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<sup>1</sup> See *infra* Part II(A).

<sup>2</sup> See, e.g., Ann Wilde Matthews, *Beyond Co-Pay: Surprise Bills at the Doctor's; To Ensure They Get Paid, Doctors Seek Entire Bill for Patient Share Upfront*, WALL ST. J., Aug. 5, 2009 (citing doctor reporting that office staff had to train patients to see doctor visits like trip to Walmart – “pay before leaving”).

<sup>3</sup> For scrutiny of that debt collection, see, e.g., Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2007); George A. Nation, III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L. J. 101 (2006).

<sup>4</sup> See *infra* Part II(A)(2).

<sup>5</sup> See *infra* tbl. 1.

Proposals to substantially restructure health care finance have intensified the interest in the financial impact of medical bills. In the summer of 2009, Professors David Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler released a new paper reporting an even higher estimate than earlier survey studies of bankruptcies prompted by medical problems.<sup>6</sup> President Obama has mentioned medical bankruptcy rates as a rationale for the need for health care reform. Lawmakers are holding hearings to look at whether the current health care system is bankrupting American families. At such a hearing in July 2009, Representative John Conyers cited findings from the Himmelstein study as evidence that health care reform is urgently needed. But a scholar from the American Enterprise Institute cited the earlier DOJ court record analysis in refuting the survey method and findings.

The instant paper is the first attempt to reconcile the competing methods of measuring medical burden that inform the current debates. We are the first researchers to use a single dataset to apply both approaches to the same set of filers. Our dataset is a nationally representative sample of people who filed for bankruptcy in early 2007, the 2007 Consumer Bankruptcy Project (“2007 CBP”). This dataset consists of hundreds of variables from court records, questionnaire information and telephone interviews. It was compiled by professors of law, medicine and sociology at seven major research universities, including one of the authors of this paper. The instant paper uses brand-new survey questions to uncover exactly what people do when they incur medical bills on the brink of bankruptcy, and new types of analyses to compare the measures.

We find that the DOJ’s court record method produces a skewed undercount of medical burden. Our court record information on medical debt is patterned very consistently with the DOJ sample with respect to key benchmarks, including the percentage of cases with over \$5,000 in medical debt. Someone who used the DOJ analysis to say that medical bills were “no big deal” in bankruptcy presumably would be nearly as happy to cite our court record analysis for the same assertion.

When we compare the court record count of medical debt to the survey data in multiple ways, we find nontrivial deviations, verifying that the two measures are not reliable stand-ins for one another. As Figure 2 displays, court records routinely produce smaller or even zero medical obligations for filers who report much more recent out-of-pocket expense on the questionnaire. Indeed, one out of four respondents who explicitly reported medical bills as a reason they filed for bankruptcy has zero identifiable medical debt in his or her court records.

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<sup>6</sup> David U. Himmelstein, Deborah Thorne, Elizabeth Warren, & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: The Results of a National Study*, 122 AM. J. MED. 741 (Aug. 2009).

After testing several theories for the discrepancies, we can explain a lot of the deviation by filers' medical bill management decisions pre-bankruptcy, which made many obligations undetectable using the DOJ's court record method. For example, respondents with bigger gaps between the measures had significantly higher rates of credit card and mortgage use for medical bills.<sup>7</sup> Due to patterns in formal credit use for medical bills, the court record measure misses some of the most significant medical obligations. Thus, the court record measure is not merely more conservative, but misleading as an estimate of burden on families. Respondents who specifically report medical bills as a reason they filed for bankruptcy mortgaged their homes for medical bills at *nearly four times* the frequency of other filers.<sup>8</sup> They also are about a third more likely to use credit cards for medical bills.<sup>9</sup>

When we disaggregate our national sample on the basis of age, race, sex, and housing tenure, we find that the distortion of medical debt burden in the court records does not affect all filers uniformly, perhaps due to uneven access to credit and medical care, or other factors. For example, court records make some filers appear as if they had incurred distinctively high medical debt when they had not; the questionnaires suggest that they merely had managed their debts differently from other filers. Other groups of filers look like they have similar medical debts when only court records are used. But information from the surveys reveals that they actually started with very different amounts of medical obligation. Again, significant variations in medical debt management alter the perception one gets from the court records.

Our findings reveal the error in using the DOJ-style court record study, by itself, to "refute" a CBP-style survey study to understand the financial impact of medical care. They also provide another perspective on medical practice management. As previously noted, non-legal writings advise how medical providers should manage the risk of transacting with patients, in part because these writers have long feared that patients will put doctors at the bottom of the priority list of bills to pay.<sup>10</sup> The respondents in the current study often were likely in serious financial trouble when they incurred the obligations and when they decided how to handle them.<sup>11</sup> Yet, by the time they filed for bankruptcy, they had considerably reduced providers' direct financial exposure. Our findings are consistent with the notion that even patients with

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<sup>7</sup> See *infra* fig. 4.

<sup>8</sup> See *infra* fig. 3.

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

<sup>10</sup> See, e.g., D.W. CATHELL, *THE PHYSICIAN HIMSELF FROM GRADUATION TO OLD AGE* (1925). See also sources cited *infra* Part IV.

<sup>11</sup> In telephone interviews with a large subset of these respondents, 44% reported that they had seriously struggled financially for more than two years before filing. An additional 27% reported serious struggling for more than one year. We do not have this information for all respondents in the sample, but the telephone survey subsample is not significantly different from the whole regarding variables such as filing status, chapter, total assets, total debts, priority debts, monthly income, and home value.

modest incomes and very high debt-to-income ratios are responsive to encouragement to reduce their direct liability to medical providers.

This paper proceeds with the following three substantive sections. Part II(A) offers background on out-of-pocket medical bills and medical practice management advice. It then contextualizes our study by reviewing the methodological and political dispute over measuring medical burden among bankruptcy filers. Part II(B) describes our dataset, with special attention to the new questions and variables that enabled us to conduct this study. Part III reports our findings. Part IV highlights some implications of our study for understanding the burden of health care on families and medical practice management.

## II: Background and Methodology

### *A. Managing Out-of-Pocket Liability*

#### 1. In General

For many reasons, today's health care finance system expressly imposes cost-sharing and direct patient liability on patients who are covered by health insurance.<sup>12</sup> According to The Coker Group, which is a health care industry consultant firm, 90% of patients owe money directly at the time of service.<sup>13</sup>

Furthermore, obligations to be collected directly from patients represent, on average, 15-20% of a medical provider's receivables.<sup>14</sup> The Centers for Medicare and Medicaid Services predict continued increases in patient out-of-pocket payments.<sup>15</sup> In an analysis of a recent Medical Expenditure Panel Survey, the

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<sup>12</sup> See generally JONATHAN GRUBER, J. KAISER FAMILY FOUNDATION REPORT # 7566, THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 1 (2006) (describing cost-sharing and reporting impact on utilization and health outcomes); Ann Kjos, New Prospects for Payment Card Application in Health Care, Fed. Res. Bank. Phila. Payment Cards Center Discussion Paper p. 1 (Nov. 2008) ("out-of-pocket expenditures, which consumers pay directly to medical service providers, are not insignificant and are expected to grow from the current level of about \$269 billion"); 2008 Milliman Medical Index, p. 9 (May 2008) ("of the "\$15,609 total medical cost for a family of four under a PPO . . . the employee pays about \$6,167," \$2,675 of which is paid in cost-sharing at time of service); The McKinsey Quarterly, Why Americans Pay More For Health Care, p. 9 (Dec. 2008) ("average" health care consumer pays 12% of total cost directly out-of-pocket, in addition to 25% of premium cost); Kaiser Family Foundation, Distribution of Out-of-Pocket Spending for Health Care Services (May 2006) (average share paid out-of-pocket by non-elderly people with private insurance and any health spending in 2003 was 34%). See generally Sarah Goodell & Paul Ginsberg, High and Rising Health Care Costs: Demystifying U.S. Health Care Spending, Robert Wood Johnson Foundation, The Synthesis Project, Policy Brief No. 16, p. 4 (Oct. 2008) (discussing consumer financial exposure as a method of controlling health care spending on low-value new technologies, assuming consumers have sufficient information).

<sup>13</sup> THE COKER GROUP, MAXIMIZING BILLING AND COLLECTIONS IN THE MEDICAL PRACTICE 41 (Am. Med. Ass'n 2007).

<sup>14</sup> Richard Haugh, *Financial Aid: From Direct Debits to New Loans, Patients Get New Ways to Pay Off Hospital Bills*, HOSPITAL AND HEALTH NETWORKS, Nov. 2006, at 18; Mitch Patridge & Doug Barry, *Compassionate Patient Financing Can Cure a Hospital's Financial Ills*, 32 J. HEALTH CARE FIN. 88, 89-90 (2006). Patridge and Barry note that these receivables represent only 2-5% of net revenue due to insufficient collection practices.

<sup>15</sup> U.S. Dept. of Health & Human Serv., Ctr. for Medicare & Medicaid Services, [www.cms.hhs.gov/nationalhealthexpenddata/03\\_nationalhealthaccountsprojected.asp#topofpage](http://www.cms.hhs.gov/nationalhealthexpenddata/03_nationalhealthaccountsprojected.asp#topofpage).

authors reported that a fifth of privately insured non-elderly families had out-of-pocket obligations exceeding 5% of their incomes.<sup>16</sup>

As an interesting sign of the times regarding these obligations, a few years ago a bank started issuing a “Healthcare Visa Gift Card.”<sup>17</sup> The website for the Visa card lists a variety of occasions for which such a gift might be appropriate.<sup>18</sup> Although new card orders are no longer being taken, the cards apparently were a “hot new Christmas gift” in December 2007.<sup>19</sup> Gift-givers could get the card in amounts ranging from \$25 to \$5,000, and using the card would be fee-free for the recipient for nine months, after which the recipient would pay a monthly maintenance fee of \$1.50.<sup>20</sup> Existing cards can be used for health club membership and totally elective surgery as well as for dental care and co-pays at doctors’ offices.<sup>21</sup>

Certainly many people with modest cost-sharing obligations or higher incomes pay immediately and without serious consequence. But contemporary studies continue to report that cost sharing results in delinquent medical debt with some prevalence,<sup>22</sup> even for routine care.<sup>23</sup> Nationally-representative studies estimate that tens of millions of households have accrued medical debt and/or problems paying medical bills.<sup>24</sup>

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<sup>16</sup> See JONATHAN GRUBER, J. KAISER FAMILY FOUNDATION REPORT # 7566, THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 11 (2006). This excludes insurance premiums. See, e.g., DIDEM BERNARD, PHD, AND JESSICA BANTHIN, PHD, MED. EXPENDITURE PANEL SURVEY, FAMILY-LEVEL EXPENDITURES ON HEALTH CARE AND INSURANCE PREMIUMS AMONG THE U.S. NONELDERLY POPULATION, 2004, 14, 15 (2007) (defining terms used in MEPS surveys).

<sup>17</sup> <http://www.givewell.com/where-to-use/> (last accessed July 22, 2009) (“Promote happiness, give a Healthcare Visa Gift Card”).

<sup>18</sup> <http://www.givewell.com/occasions-to-give/> (last accessed July 22, 2009).

<sup>19</sup> *Medical Gift Cards Trendy*, HEALTH CARE COLLECTOR, Feb. 2008, at 11.

<sup>20</sup> <http://www.givewell.com/how-it-works/> (last accessed July 22, 2009).

<sup>21</sup> *Id.*

<sup>22</sup> Many published papers and unpublished online policy briefs make this point. For recent examples, see, e.g., Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. 298, 304 tbl.4 (2008) (reporting that increasingly significant proportions of insured population pay out-of-pocket); Sidney D. Watson et al., *Living in the Red: Medical Debt and Housing Security in Missouri* (The Access Project 2007); Andrew Cohen & Carol Pryor, *In Debt But Not Indifferent: Chapter 58 and The Access Project’s Medical Debt Resolution Program* (Access Project 2008).

<sup>23</sup> See, e.g., William Lottero et al., *Losing Ground: Eroding Health Insurance Coverage Leaves Kansas Farmers with Medical Debt*, The Access Project, 10 (July 2006) (60% with medical debt reported owing money for routine care); PAUL FRONSTIN & SARA R. COLLINS, EMPLOYEE BENEFIT RESEARCH INST., FINDINGS FROM THE 2007 EBRI/COMMONWEALTH FUND CONSUMERISM IN HEALTH SURVEY 9-10 (2008); Peter J. Cunningham, Carolyn Miller, & Alwyn Cassil, *Living on the Edge: Health Care Expenses Strain Family Budgets*, Center for Studying Health System Change Research Brief No. 10, 3 (Dec. 2008) (explaining how trouble paying medical bills can result from non-catastrophic expenses); Jessica S. Bantthin et al., *Financial Burden of Health Care, 2001-2004*, 27 HEALTH AFF. 188 (2008) (studying out-of-pocket obligations plus premium costs across population).

<sup>24</sup> In a Commonwealth Fund study, 72 million “working age” people, and an additional 7 million over 65, had accrued medical debt and/or problems paying medical bills, an increase over earlier studies. Sara R. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families*, 42 COMMONWEALTH FUND 1 (2008); Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults 2003 and 2007*, 27

Concerns about medical debt are longstanding and have transcended the evolution of health care finance.<sup>25</sup> Health policy researchers and patient advocates have articulated specific worries about how medical debt affects patients and their families. Prominent examples of such worries include: patients may self-ration medically necessary care and drugs;<sup>26</sup> medical providers may deny non-emergency care;<sup>27</sup> patients may self-ration important *non*-medical expenses;<sup>28</sup> providers or their designees may engage in harsh formal debt collection activity;<sup>29</sup> patients may experience adverse psychological consequences from fear about medical debt that in turn may aggravate health conditions;<sup>30</sup> certain demographic groups may be disproportionately impacted by cost-related or debt-related access problems;<sup>31</sup> and patients may experience pressures to convert medical debt into third-party credit that could substantially increase the size of those bills and other consequences.<sup>32</sup>

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HEALTH AFF. 298, 304 tbl.4 (2008) (reporting 16% were contacted by debt collectors about medical bills). In another study, 57 million people in 2007 (14 million more than in 2003) were in households with trouble paying medical bills. Peter J. Cunningham, Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families 2003-2007, Center for Studying Health Care Change Tracking Report No. 21 (Sept. 2008).

<sup>25</sup> See, e.g., Jonathan Cohn, *This Won't Hurt a Bit: Health Care Reform for Dummies*, THE NEW REPUBLIC, Feb. 18, 2009, at 18 (reporting on the Committee on the Costs of Medical Care from the 1930s and the concern that medical bills destabilize household finances); *Special Report: Doctor Bills Pile Up: How Can Families Pay?*, U.S. NEWS & WORLD REP., Oct. 17, 1952, at 65-70 (reporting on academic study finding that one in five families had outstanding medical debt); Editorial, *Most People Need No Aid to Pay the Doctor's Bill*, SATURDAY EVENING POST, Jan. 10, 1953, at 10, 12 (arguing that U.S. News story was an overreaction to data from academic study).

<sup>26</sup> This point is frequently made. For a few recent entries to the literature, see, e.g., Cathy Schoen et al., *In Chronic Condition: Experiences of Patients with Complex Health Care Needs in Eight Countries*, 2008, 28 HEALTH AFF. w1, w5 (Nov. 2008) (discussing cost-related deterrence of treatment, particularly among U.S. patients); Robert W. Seifert & Mark Rukavina, *Bankruptcy is the Tip of a Medical Debt Iceberg*, HEALTH AFF. Web Exclusive (Feb. 2006); Peter J. Cunningham & Laurie E. Felland, *Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007*, Center for Studying Health System Change Tracking Report No. 19 (June 2008) (noting cost was "most frequently cited -- and growing -- obstacle to care").

<sup>27</sup> See, e.g., Peter J. Cunningham, Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families 2003-2007, Center for Studying Health Care Change Tracking Report No. 21 (Sept. 2008) ("In 2007, about 10% of people with medical bill problems reported being denied care by medical providers directly as a result of their medical bill problems").

<sup>28</sup> See, e.g., Peter J. Cunningham, Carolyn Miller, & Alwyn Cassil, *Living on the Edge: Health Care Expenses Strain Family Budgets*, Center for Studying Health System Change Research Brief No. 10, 4-5 (Dec. 2008) (discussing families who are late on mortgages and cut down other expenses due to medical bill problems); *id.* at 8 (discussing choice between medical bills and keeping children housed and fed); Robert W. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 51 ST. LOUIS U. L. J. 325 (2007).

<sup>29</sup> See generally Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535 (2006) (documenting concerns of patient advocates).

<sup>30</sup> See, e.g., Carol Pryor, Andrew Cohen & Jeffrey Prottas, *The Illusion of Coverage* (Access Project 2007); Wilhelmine Miller, Elizabeth Richardson Vidgor, and Willard G. Manning, *Covering the Uninsured, What is it Worth?*, HEALTH AFF. W40-157, 162 (Web Exclusive Mar. 2004) ("The social stigma and psychological stresses of medical indigency, health care debt, and bill collection efforts are themselves burdensome").

<sup>31</sup> See, e.g., Elizabeth M. Patchias & Judith Waxman, *Women and Health Coverage: The Affordability Gap*, p. 5-6 (Commonwealth Fund Issue Brief Apr. 2007) (reporting on medical debt among people with health insurance).

<sup>32</sup> See, e.g., Peter J. Cunningham, Carolyn Miller, & Alwyn Cassil, *Living on the Edge: Health Care Expenses Strain Family Budgets*, Center for Studying Health System Change Research Brief No. 10, 5, 7 (Dec. 2008) (giving examples of credit card, mortgages, and personal loan use for medical bills); Sara Collins et al., *The Affordability*

The world looks different from the perspective of the medical practice management field. Writers in this field focus on how to protect health care *providers*, rather than patients, from bad debt. While scholars from many disciplines continue to debate whether medical care should be treated as an ordinary commodity,<sup>33</sup> those on the front lines of practical advice to providers proceed from the assumption of commercial exchange to a large extent.<sup>34</sup> For the most part, a report published by the American Medical Association strongly emphasizes this theme, reminding doctors that “It’s your money - ask for it!”<sup>35</sup>

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Crisis in Health Care (Commonwealth Fund 2004) (one in five medical debtors had large credit card debt or home mortgage to pay medical bills); Mark Rukavina & Cindy Zeldin, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses* (Demos & The Access Project, Jan. 2007); UNHEALTHY PURSUITS: HOW THE SICK AND VULNERABLE ARE HARMED BY ABUSIVE MEDICAL COLLECTION TACTICS, NAT. CONSUMER L. CTR. 36 (2005) (suggesting that providers have encouraged patients to take on high-cost credit for bills); USA Today/Kaiser Family Foundation/Harvard School of Public Health, *Health Care Costs Survey, Summary and Chartpack*, Chart 3 (Aug. 2005) (reporting that 8% borrowed money or got second mortgages because of problems paying medical bills); Demos and Center for Responsible Lending, *The Plastic Safety Net* p. 56-57 (Oct 2005) (reporting that medical bills contributed to credit card debt for 29% of low and middle income households); Brian Grow & Robert Berner, *Fresh Pain for the Uninsured: As Doctors and Hospitals turn to GE, Citi, and Smaller Rivals to Finance Patient Care, the Sick Pay Much More*, BUS. WK., Dec. 3 2007 (reporting on loan arranging for bills of patients who were unaware of the third-party arrangement). In a recent tracking survey, about one in ten respondents with problems paying medical bills reported that their providers suggested that they take out loans to meet their health care obligations. Peter J. Cunningham, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families 2003-2007*, Center for Studying Health Care Change Tracking Report No. 21, p. 3 (Sept. 2008). Two national publications recently cited Senator Grassley’s concern that medical providers are “cozying up to banks, debt buyers, and credit card companies over patients’ medical bills.” Brian Grow & Robert Berner, *Fresh Pain for the Uninsured: As Doctors and Hospitals turn to GE, Citi, and Smaller Rivals to Finance Patient Care, the Sick Pay Much More*, BUS. WK., Dec. 3 2007, at 34 (quoting statement that Senator Grassley provided to Business Week); *Overdose of Debt: Lenders Push Risky Credit for Everything from Cancer Care to Botox*, CONSUMER RPTS, July 2008, 14, 18 (reporting same statement).

<sup>33</sup> Mark A. Hall & Carl E. Schneider, *The Professional Ethics of Billing and Collections*, 300 J. AM. MED. ASS’N 1806 (2008); Pamela Hartzband & Jerome Groopman, *Money and the Changing Culture of Medicine*, 360 N. ENG. J. MED. 101 (2009); Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POL’Y & L. 533 (1997); Philip E. Tetlock, *Coping with Trade-Offs: Psychological Constraints and Political Implications*, in *ELEMENTS OF REASON: COGNITION, CHOICE, AND THE BOUNDS OF RATIONALITY* 251 (Arthur Lupia et al. eds., 2000) (“[I]berals view the buying and selling of conventional medical services and, to some degree, legal services as suspect categories—people seem to be buying health, life, and justice—whereas conservatives are not bothered by such transactions.”); Marc A. Rodwin, *Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest*, 16 CAMBRIDGE Q. OF ETHICS 387 (2007).

<sup>34</sup> See generally Mark A. Hall & Carl E. Schneider, *The Professional Ethics of Billing and Collections*, 300 J. AM. MED. ASS’N 1806 (2008) (discussing model generally used by health care providers).

<sup>35</sup> Specifically, The Coker Group report advises:

If, for some reason, the patient indicates an inability to make a payment, the staff member should call the billing manager . . . The manager should take the patient to a private room to discuss payment. The element of authority imposed by the billing or practice manager indicates that nonpayment is unacceptable. At the discretion of the manager, the patient may be allowed to leave without paying, but, preferably, with an agreed-upon plan for payment. In some cases, a fee should be charged if the patient is to be billed. . . . The long-range goal is to develop the understanding that arrangements for payments must be made in advance of the patient encounter. As with most matters related to credit and collection policy, it is essential to be consistent across the patient base. Consistent patterns of collection inform both the staff and the patients that direct patient payment is important. It’s your money – ask for it!

THE COKER GROUP, *supra* note 13, at 43.

Medical practice management writings may instruct providers on such matters as how to get payments up front (including before services are rendered),<sup>36</sup> how to financially screen patients,<sup>37</sup> when to terminate or embargo patients for nonpayment,<sup>38</sup> how to physically arrange a medical office or hospital to encourage payment,<sup>39</sup> what color envelopes should be used for medical bill collection letters,<sup>40</sup> and even the optimal physical posture a staff member should assume when attempting to collect from patients.<sup>41</sup> Sources recommend making a “game” out of billing for employees to maximize receipts,<sup>42</sup> or motivating billing

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<sup>36</sup> Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, April 2, 2007 (citing health care consultant saying “‘Everyone needs to sign on that we are going to collect co-pays at the time of service.’ . . . The patient needs to be reminded over and over that this is the new system.”); Deborah Shapiro, *How to Address Patient Payments: Can’t Pay . . . Won’t Pay . . . Should Pay*, HEALTH CARE COLLECTOR, March 2008, at 3 (“The best time to collect money from patients is before the service is rendered, or at least right after the service and before they walk out the door.”); Kim LaFontana & Kim Williams, *Practice Management Lab: Findings Success with Self-Pay*, PHYSICIANS PRAC., July/Aug. 2006 (referring to time of service as the “golden moment” for collecting payments from patients); Judy Capko, *Physicians Practice Pearls: You Earned it, Now Collect it*, PHYSICIANS PRAC., June 2007 (recommending payments at time of service).

<sup>37</sup>For evidence of interest in financial screening of patients, see, e.g., Emily Berry, *Taking a Financial History: Determining the Health of Your Patient’s Credit Rating*, AM. MED. NEWS, Jan. 19, 2009; *Financial Triage: Innovative Ways That Hospitals are Looking at Patient Finances*, BUS. WK., Nov. 20, 2008; Dave Hansen, *Giving credit to get what’s due: How doctors can help patients pay the bill*, AM. MED. NEWS, Jan. 21, 2008; Judie I. Veazie, *Point-Of-Service Collections: When it’s Too Late to Collect*, HEALTH CARE COLLECTOR, Feb. 2009, at 4, 5 (reporting use of credit reports by providers to determine approach for self-pay portion of bills); *Overdose of Debt: Lenders Push Risky Credit for Everything from Cancer Care to Botox*, CONSUMER RPTS, July 2008, at 14, 17 (reporting on hospitals’ use of credit scores or credit reports, and Equifax’s Payment Predictor system); *Maximizing Self-Pay Collections: Moving the Process Ahead*, HEALTH CARE COLLECTOR, Jan. 2009, at 10 (discussing how hospitals may wish to use credit scoring or reporting “to get a glimpse of the patient’s financial situation”).

<sup>38</sup> See, e.g., ROBERT J. SOLOMON, *THE PHYSICIAN MANAGER’S HANDBOOK: ESSENTIAL BUSINESS SKILLS FOR SUCCEEDING IN HEALTH CARE* 107-08 (2D ED. 2008) (in sample collection plan, providing suspension of future appointments for patient who misses two successive co-payments until payment is satisfied); Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, Apr. 2, 2007 (paraphrasing Jeff Peters, CEO of Health Directions, a Chicago-based consulting firm, “[t]here’s no crime in telling patients their balance must be paid or arrangements for payment be made before they get another appointment.”); Shirley Grace, *Physician Beware: ‘The Dog Ate My Checkbook’*, PHYSICIANS PRAC., Feb. 2009; THE COKER GROUP, *supra* note 13, at 41, 57 (recommending dismissing a chronic non-paying patient from a medical practice (particularly if it seems to the provider that the patient is not really in financial hardship) or “embargoing” a delinquent patient until the debt is satisfied); Wayne J. Guglielmo, *Practice Pointers: When Patients Can’t Pay*, MED. ECON., June 3, 2005; Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, Apr. 2, 2007. One author compared conditioning treatment on payment for prior service to conditioning a future movie rental on payment for a prior rental. Curt Mayse, *Front Desk as Profit Center*, PHYSICIANS PRAC. (Apr. 2005).

<sup>39</sup> See, e.g., Suz Redfearn, *Pay Up, Self-Payer: Getting the Most from Patients Who Pay Out-Of-Pocket*, PHYSICIANS PRAC., Mar./Apr. 2002 (recommending that office be set up to require patient to pass collections desk to exit).

<sup>40</sup> See, e.g., *Ten Tips for Improving Collection Letters*, HEALTH CARE COLLECTOR, March 2009, at 12 (recommending medical providers “test pastel-colored envelopes that will stand out against other mail” and the use of “p.s.” to emphasize strongest points relating to collection).

<sup>41</sup> *Collecting Assertively is an Acquired Skill: Confidence and Empathy Are Key*, HEALTH CARE COLLECTOR, Dec. 2007, at 7, 8 (recommending “good posture – no slouching” while collecting medical bills in person or on phone).

<sup>42</sup> Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, Apr. 2, 2007.

and collections employees with coffee cups, T-shirts, gift certificates, additional vacation days, or merit certificates.<sup>43</sup>

Significantly, if doctors adhere to the advice with some success, they may be able to avert the need for formal and more public *ex post* debt collection efforts in which they have long participated.<sup>44</sup> The practice management literature thus implicitly and explicitly encourages medical providers to shift the risk of patient non-payment to third-party creditors: the common advice is, whenever possible, to “push the problem of nonpayment to someone else.”<sup>45</sup>

Credit cards facilitate the expectation in the health care marketplace that the patient will resolve the self-pay portion of a medical bill, in a “retail business” fashion, at the time of service.<sup>46</sup> When recommending taking credit card imprints before fully assessing liability or before offering medical services, authors

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<sup>43</sup> THE COKER GROUP, *supra* note 13, at 38.

<sup>44</sup> See, e.g., Robert B. Avery et al., *An Overview of Consumer Data and Credit Reporting*, 89 FED. RES. BULL. 47, 67, 69 (2003) (using earlier data, estimating that medical bills accounted for 18.2% of court judgments on credit reports and 52.2% of collection agency actions).

<sup>45</sup> Karen Caffarini, *Keeping Rubber Checks from Clogging Revenue Flow*, AM. MED. NEWS, Jan. 26, 2009; See also Mitch Patridge & Doug Barry, *Compassionate Patient Financing Can Cure a Hospital's Financial Ills*, 32 J. HEALTH CARE FIN. 88, 89-90 (2006) (“Whether in the form of credit cards, bank loans, or the more widely used electronic paper-free funding programs, it is critical that the hospital offer reasonable options to the patient without placing financial burdens on the hospital such as carrying long-term payment plans.”); Mari Edlin, *A Fair Trade? Make Payment Policies Fair and Legal*, PHYSICIANS PRAC., Nov. 2001 (citing practice manager saying: “We are not a bank. Take out a loan or charge it.”); Suz Redfearn, *Pay Up, Self-Payer: Getting the Most from Patients Who Pay Out-Of-Pocket*, Physicians Practice, March/April 2002 (citing consultant recommending that providers “forge relationships with local banks that can quickly arrange to grant small loans to patients.”); Jeffrey C. Levitt, *Transfer of Financial Risk and Alternative Financing Solutions*, 30 J. HEALTH CARE FIN. 21, 26 (2004) (“Likewise, medical providers would rather have another party take the financial exposure from patients rather than keep it on their own balance sheets. They are in the business of providing health care, not consumer financing.”); Pamela Moore, *Billing and Collections: Playing Hardball: Advice on Charging Interest and Late Fees on Past-Due Patient Accounts*, PHYSICIANS PRAC., Apr. 2008 (encouraging providers to get patients to use credit card for balances, or to offer products like CareCredit so “patient can work out his troubles with someone else”); Wayne J. Guglielmo, *Practice Pointers: When Patients Can't Pay*, MED. ECON., June 3, 2005 (experts suggest encouraging patients to put bill on credit card, rather than payment plan with provider, if patient is employed and not in particularly bad financial shape to “shift[ ] the credit burden . . . to the credit card company.”); THE COKER GROUP, *supra* note 13, at 41; ROBERT J. SOLOMON, *THE PHYSICIAN MANAGER'S HANDBOOK: ESSENTIAL BUSINESS SKILLS FOR SUCCEEDING IN HEALTH CARE* 83 (2D ED. 2008) (to make patient prioritize medical bills, “[r]emind the patient that he or she can use a credit card.”); Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, April 2, 2007 (reporting on consultant advising that medical practices should accept “all credit cards.”).

<sup>46</sup> Kris Hundley, *As Medical Costs Grow, Creditors Get in the Game*, TAMPA BAY TIMES, Feb. 24, 2008 (referring to retail business model); Elizabeth S. Roop, *Debt Load: Building a Better Payment Plan (for Hospitals and their Patients)*, 82 HOSPITALS AND HEALTH NETWORKS 46, 47 (June 2008) (reporting on how a medical facility “vigorously pursues upfront payments . . . patients are given the opportunity to make a payment over the phone, which speeds collection for the hospital. A 20% discount is provided for up-front payments”); Dave Hansen, *Giving credit to get what's due: How doctors can help patients pay the bill*, AM. MED. NEWS, Jan. 21, 2008; Patrick Reilly, *Extracting Payment; Hospitals Try Collecting Before Patients Leave ER*, MOD. HEALTHCARE, Nov. 17, 2003, at 8; Judie I. Veazie, *Point-Of-Service Collections: When it's Too Late to Collect*, HEALTH CARE COLLECTOR, Feb. 2009, at 4, 5 (“point-of-service tools, including the acceptance of credit cards, are very important”).

analogize medical services to hotels and car rental businesses.<sup>47</sup> Health industry consultants have extended such analogies by recommending the development of “sales finance similar to those offered by appliance and auto dealers” for particularly large out-of-pocket medical expenditures.<sup>48</sup>

Providers and hospitals do commonly take credit cards notwithstanding the servicing fees they must pay,<sup>49</sup> and a Federal Reserve Payment Card Center researcher has noted that doctors’ offices more routinely include credit and debit card kiosks.<sup>50</sup> Not surprisingly, providers that have minimized ongoing patient receivables report a higher rate of accepting credit cards (92.2%).<sup>51</sup> Although the total volume of credit card receivables for medical bills remains murky, estimates are in the tens of billions and, at least before the implementation of the CARD Act, were expected to multiply.<sup>52</sup>

Issues surrounding medical billing and payment are complicated further in the context of emergency hospital care. The Emergency Medical Treatment and Active Labor Act, enacted in 1986, requires that hospitals provide services to anyone in need of emergency care, regardless of ability to pay.<sup>53</sup> With emergency room revenue (or any revenue) being important to a hospital’s bottom line,<sup>54</sup> much management literature advises on how to effectively seek payment while complying with federal law.

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<sup>47</sup> Nick A. LeCuyer & Shubham Singhal, *Overhauling the U.S. Health Care Payment System*, MCKINSEY Q. p. 6 (Web exclusive June 2007) (offering hotel and car rental analogy); Jayne Oliva, *Consumer Directed Health Care: Zeroing in on Physician Practices*, THE PHYSICIAN EXECUTIVE, May-June 2005, at 66, 67 (“Today’s self-service generation will impel health care to mirror the banking industry” in terms of service delivery formats).

<sup>48</sup> Nick A. LeCuyer & Shubham Singhal, *Overhauling the U.S. Health Care Payment System*, MCKINSEY Q. (Web exclusive June 2007) at 6.

<sup>49</sup> See, e.g., Jonathan G. Bethely, *Collecting Patients’ Share Up-Front Getting Easier*, AM. MED. NEWS, Feb. 27, 2006; Mari Edlin, *A Fair Trade? Make Payment Policies Fair and Legal*, PHYSICIANS PRAC., Nov. 2001 (noting that majority of physician offices accept credit cards); Jeffrey C. Levitt, *Transfer of Financial Risk and Alternative Financing Solutions*, 30 J. HEALTH CARE FIN. 21, 26 (2004) (reporting that most hospitals accept credit cards for payment). But see *Credit Cards and Medical Expenses; Combination Creates Dilemma for Patients, Providers*, THE RECEIVABLES REP., Apr. 2007, at 3 (from Hospital Accounts Receivable Analysis survey, reporting that only 47% of hospitals reported offering their patients the option of paying bills with credit cards).

<sup>50</sup> Ann Kjos, *New Prospects for Payment Card Application in Health Care*, Fed. Res. Bank. Phila. Payment Cards Center Discussion Paper 6 (Nov. 2008).

<sup>51</sup> Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, April 2, 2007 (citing Medical Group Management Association’s 2006 study of Performance and Practices of Successful Medical Groups).

<sup>52</sup> According to secondary reporting on a Visa USA study, credit cards were used for about a third (or \$86 billion in 2005) of paid out-of-pocket health expenditures. Ann Kjos, *New Prospects for Payment Card Application in Health Care*, Fed. Res. Bank. Phila. Payment Cards Center Discussion Paper 2 (Nov. 2008). McKinsey consultants recently offered a \$45 billion estimate in credit card self-pay health spending, but predicted a multiplication of this figure in the near future. Nick A. LeCuyer & Shubham Singhal, *Overhauling the U.S. Health Care Payment System*, MCKINSEY Q. (Web exclusive June 2007). Some, although not all, of these estimates preceded the financial crisis.

<sup>53</sup> 42 U.S.C. § 1395dd (2006). Emergency intake personnel are also prohibited from delaying treatment to inquire about a patient’s ability to pay or insurance status. See 42 U.S.C. § 1395dd(h).

<sup>54</sup> Michael S. Friedberg, *Patient Access: A New Face for the Revenue Cycle*, HEALTH CARE FIN. MAN., March 1, 2007, at 87. For evidence that emergency room services are perceived as relatively unprofitable, see Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, HEALTH AFF., May/June 2005, at 790, 792, Exh. 1.

Experts emphasize prompt screening and one notes that, “the best-performing hospitals ensure that a high percentage of [emergency department] patients are financially screened prior to discharge.”<sup>55</sup> After a patient is stabilized, emergency billing and collections practice thus resemble those already discussed. For instance, one consultant advises against an emergency department layout with multiple exits because they make it easier for patients to leave without discussing finances.<sup>56</sup> This same source cites the benefits of incentive programs for collections staff and lists credit card equipment as among the “nuts and bolts” of the emergency room collections process.<sup>57</sup>

Medical-specific credit products present another avenue for shifting risk away from providers.<sup>58</sup> Medical providers typically do not bear legal liability for being “arrangers” of credit.<sup>59</sup> By contrast, providers who directly extend credit face compliance with and potential liability under federal truth in lending laws,<sup>60</sup> as

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<sup>55</sup> Michael S. Friedberg, *Patient Access: A New Face for the Revenue Cycle*, HEALTH CARE FIN. MAN., March 1, 2007, at 87.

<sup>56</sup> *Growing focus on ED collections: Here are tips*, Hospital Access Management. April 1, 2009.

<sup>57</sup> *Id.*

<sup>58</sup> See, e.g., Milt Freudenheim, *Creating Financing; Medicine on Installment Plan: Doctors Offering Loans at 0%*, N.Y. TIMES, Aug. 30, 2007 (describing medical financing as “one of the fastest-growing parts of consumer credit, led by lending giants like Capital One and Citigroup and the Care Credit Unit of General Electric.”); Dave Hansen, *Giving credit to get what’s due: How doctors can help patients pay the bill*, AM. MED. NEWS, Jan. 21, 2008; Brian Grow & Robert Berner, *Fresh Pain for the Uninsured: As Doctors and Hospitals turn to GE, Citi, and Smaller Rivals to Finance Patient Care, the Sick Pay Much More*, BUS. WK., Dec. 3 2007, at 34 (referring to the “little-known medical debt revolution” and reporting that “Many patients say they don’t realize their debts are being shifted to such interest-charging middlemen as GE Money Bank”). Recent examples of medical-specific credit products, designed largely to supplement insurance, include the CarePayment card by Aequitas Capital Management, Care Credit by General Electric, Capital One, Citigroup, Hospital Expense Loan Program (HELP Financial), U.S. Bank’s medical card, Complete Care, and MedKey Inc. Brian Grow & Robert Berner, *Fresh Pain for the Uninsured: As Doctors and Hospitals turn to GE, Citi, and Smaller Rivals to Finance Patient Care, the Sick Pay Much More*, BUS. WK., Dec. 3 2007, at 34 (reporting on interest rates charged by medical credit providers but noting that interest isn’t always charged when parties buy the debt at discount and expect to collect full amount); *Everything from Cancer to Botox; Big Promos and Fine Print*, CONSUMER REP., July 2008, at 14 (listing medical credit “pitches” to patients and doctors); Kris Hundley, *As Medical Costs Grow, Creditors Get in the Game*, TAMPA BAY TIMES, Feb. 24, 2008 (reporting on hospital relationships with medical credit providers and interest rates as compared to some in-house payment plans); Merchant Payment Trends: Card Industry Looks to Seal a Health Care Payments Gap, CARDS & PMTS (Aug. 2007) (discussing CarePayment credit cards); MedKey Healthcare Finance, <http://www.medkeyinc.com/> (last visited Sept. 18, 2008) (offering line of credit for medical bills, 90 days interest free, 5.99% thereafter); Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w307 (June 2008) (referring to medical debt as new “growth industry”).

<sup>59</sup> Federal consumer credit laws no longer include arrangers of credit under the Truth in Lending Act (TILA). King v. Second City Constr. Co., 1997 U.S. Dist. LEXIS 15696, at \*9 (N.D. Ill. Sept. 30, 1997) (“At one time, the definition of creditor under the TILA and its implementing regulations included “arrangers of credit.” However, that portion of the definition was deleted from both the statute and the regulations in 1982.”). We could find no evidence that state loan arranger or broker statutes have been applied to medical providers. For an example of a state broker statute, see, e.g., IND. CODE ANN. §23-2-5-3(d) (Lexis Nexis 2008) (defining loan broker as “any person who, in return for any consideration from any source procures, attempts to procure, or assists in procuring a loan from a third party or any other person”); IND. CODE ANN. §23-2-5-20 (LexisNexis 2008) (imposing licensing requirements, and establishing liability for problems arising under loan agreement).

<sup>60</sup> 12 C.F.R. §226.2(a)(17) (2008) (portion of regulation Z defining creditor as “a person (A) who regularly extends consumer credit that is subject to a finance charge or is payable by written agreement in more than 4 installments

well as state credit laws or deceptive practices statutes.<sup>61</sup> This divergence in legal consequences not only contributes to reluctance of providers to charge interest when they do extend credit,<sup>62</sup> but increases the attractiveness of matchmaking patients with specialty credit products.

Medical credit products may be integrated with health care finance more generally: providers of insurance products or self-insuring companies may join with banks to offer lines of credit for the self-pay portion of bills.<sup>63</sup> Health savings accounts (HSAs), part of high-deductible health plans, may be directly

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(not including a down payment), and (B) to whom the obligation is initially payable, either on the face of the note or contract, or by agreement when there is no note or contract.”). *See also* Bright v. Ball Memorial Hosp., 616 F.2d 328, 335 (7th Cir. 1980) (finding that a hospital can be “creditor” for purposes of TILA); James H. Backman, *Consumer Credit and the Learned Professions of Law and Medicine*, 176 B.Y.U. L. REV. 783; William D. Warren & Thomas R. Larmore, *Truth in Lending: Problems of Coverage*, 24 STAN. L. REV. 793, 819-20 (1972) (discussing refusal to exempt medical providers and other “professionals” from TILA, but noting some accommodations for installment payment practices); Dave Hansen, *Giving credit to get what’s due: How doctors can help patients pay the bill*, AM. MED. NEWS, Jan. 21, 2008; Mari Edlin, *A Fair Trade? Make Payment Policies Fair and Legal*, PHYSICIANS PRAC., Nov. 2001 (recommending disclosures to comply with TILA if providers use payment plans); Pamela Moore, *Billing and Collections: Playing Hardball: Advice on Charging Interest and Late Fees on Past-Due Patient Accounts*, PHYSICIANS PRAC., Apr. 2008 (recommending late fees rather than interest to ease TILA compliance); Wayne J. Guglielmo, *Practice Pointers: When Patients Can’t Pay*, MED. ECON., June 3, 2005 (discussing legal implications of falling within consumer credit definitions); Todd Stein, *Patients, Pay Up! You’d Better Have a Financial Policy*, PHYSICIANS PRAC., Mar. 2005 (warning providers that if they charge interest, they should have an attorney review their policy for compliance with lending laws; “Because the rules are complex, most practices choose not to charge interest on balances owed.”).

<sup>61</sup> *See, e.g.*, Anderson v. Southeast AL Med. Ctr., 381 So.2d 68, 70 (AL Civ. App. 1979) (finding that defendant hospital was a “creditor” under ALA. CODE §5-19-1(3) (1975) but did not impose finance charges for outstanding debt); Richard M. Alderman, *The Business of Medicine- Health Care Providers, Physicians, and the Deceptive Trade Practices Act*, 26 HOUS. L. REV. 109, 140 (1989).

<sup>62</sup> The AMA code of medical ethics, which is non-binding, suggests that providers notify patients of the possibility of charging interest in advance of treatment. *See* AMA Code of Ethics 6.08, p. 183-84 (2008); Health and Ethics Policies of the AMA House of Delegates E-6.08. But charging interest does not seem to be the norm among medical providers. *See* Mari Edlin, *A Fair Trade? Make Payment Policies Fair and Legal*, PHYSICIANS PRAC., Nov. 2001 (reviewing negative aspects of doctors imposing finance charges); Pamela Moore, *Billing and Collections: Playing Hardball: Advice on Charging Interest and Late Fees on Past-Due Patient Accounts*, PHYSICIANS PRAC., Apr. 2008 (citing consultant characterizing charging interest as “touchy area” and discouraging it); Todd Stein, *Patients, Pay Up! You’d Better Have a Financial Policy*, PHYSICIANS PRAC., Mar. 2005 (“... most practices choose not to charge interest on balances owed.”); Dave Hansen, *Giving credit to get what’s due: How doctors can help patients pay the bill*, AM. MED. NEWS, Jan. 21, 2008 (citing a consultant reporting that “many” medical practices do not charge interest, but that “it is prevalent for expensive medical procedures” and another saying that “It’s common for physicians to collect bills without charging interest,” with a practice group reporting that it charges 6% annual interest if the bill is stretched out for more than six months); Cheryl L. Toth, *Payment Plans for Patients: Better Collections for You*, PHYSICIANS PRAC., Jan./Feb. 2003 (discussing downsides of charging interest). For a recent controversial example, *see, e.g.*, Press Release, The Office of Attorney General Lori Swanson, *Attorney General Lori Swanson Files Suit Against Allina Health System for charging usurious 18% interest on medical debts*, Jan. 22, 2009, <http://www.ag.state.mn.us/Consumer/PressRelease/090122AllinaInterest.asp> (alleging provider charged 18% interest on outstanding balances up to \$4,999 and 12% on balances from \$5,000 to \$9,999 in violation of Minnesota law). *See* Minn. Stat. §334.01(1) (2008) (stating legal rate of interest as 6% annually and maximum rate is 8%).

<sup>63</sup> *See, e.g.*, Milt Freudenheim, *Creating Financing; Medicine on Installment Plan: Doctors Offering Loans at 0%*, N.Y. TIMES, Aug. 30, 2007 (“Big insurers, too, are devising new financing plans with various payback options.”); John Carroll, *Banks Give Insurers an Offer Most of Them Cannot Refuse, Managed Care*, July 2006 (“Companies with self-funded or self-insured health plans started offering employees a line of credit” from a bank that is a subsidiary of UnitedHealth Group . . . the One Pay Plan . . .); One Bill, One Pay: Pilot Program Simplifies Billing

linked with credit or debit cards.<sup>64</sup> The justification for offering adjunct credit products is so consumers can bridge the gap between large deductibles and more meager HSA contents.<sup>65</sup> Several companies have filed applications for business method patents for HSA payment systems with credit line components, suggesting significant investment in the combination of financing approaches.<sup>66</sup>

In summary, the current health care system features constant, regular financial transacting between providers and their patients regardless of patients' insurance status. The non-trivial number of patients with some difficulty handling self-pay obligations imposes additional financial risks on providers. The recommended approaches to managing these risks encourage early payoff of health care providers and seek to avoid later legal enforcement to the extent possible.

The practices that providers adopt to shape their financial transacting affect the ways in which researchers can measure patients' medical burden. We turn to this in the following subsection, focusing specifically on the measurement of burden for people who have filed for bankruptcy.

## 2. Measuring Medical Burdens of Bankruptcy Filers

Researchers have differed in their methods of identifying medical bills and medical problems among people who file for bankruptcy.<sup>67</sup> Most studies use self-reported information in one form or another.<sup>68</sup>

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for Consumers and Physicians, Hub Magazine (reporting that interest rate was set at prime rate, and consumer makes payment through payroll deduction). See generally E. Haavi Morreim, High-Deductible Health Plans: Litigation Hazards for Health Insurers, 18 HEALTH MATRIX 1, 30 (2008) (describing One Pay plan and potential problems); Sarah Rubenstein, *In New Health Plan, Patients Pay Their Share – Or Else*, WALL ST. J., Mar. 13, 2006, at B1; Nick A. LeCuyer & Shubham Singhal, *Overhauling the U.S. Health Care Payment System*, MCKINSEY Q. (Web exclusive June 2007) (recommending that insurance providers offer credit lines to policy holders).

<sup>64</sup> See, e.g., Jennifer Roy, HSA Lines of Credit, HSA HealthLine, www.choicefinancialgroup.com (providing terms for Choice Financial's line of credit); Chase Health Savings Account, Healthcare Line of Credit, www.chasehsa.com) (setting rate at 13.99% for interest rate on credit line); Provident Bank, Health Savings Account (HSA) Line of Credit, web.provbank.com (setting 11.75% rate for loans up to \$10,000 and encouraging use of line of credit as overdraft protection); Visa Health Savings Account Card, usa.visa.com (combining line of credit with health insurance identification card, capability of accessing other accounts, and reimbursement arrangements); US Bank, Health Savings Solution Product Guide (including line of credit); Richard Haugh, *Financial Aid: From Direct Debits to New Loans, Patients Get New Ways to Pay Off Hospital Bills*, HOSPITAL AND HEALTH NETWORKS, Nov. 2006, at 18; Merchant Payment Trends: Card Industry Looks to Seal a Health Care Payments Gap, CARDS & PMTS (Aug. 2007); Companies Offer Nation's First Credit Line to Owners of Health Savings Accounts, Business Wire, June 27, 2005; Tony Miller, *Getting on the Soapbox: Views of an Innovator in Consumer-Directed Care*, Health Aff., Web Exclusive w549, w550 (2006).

<sup>65</sup> See, e.g., UMB Healthcare Services' Dennis Triplett Offers Perspective on HSA Line of Credit Solution, Business Wire, Aug. 2, 2006.

<sup>66</sup> See United States Patent Application Publication of Jasperse et al, Pub. No. US 2006/0200397 A1 (Sept. 7, 2006).

<sup>67</sup> For literature reviews, see Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377 (2001) (summarizing earlier literature and referring to the bankruptcy system as an "overlooked source of information for purposes of the health care finance policy debates"); Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS U. L. J. 301 (2007) (distinguishing studies of debt from studies of medical-related financial problems).

Law professors Elizabeth Warren and Jay Westbrook and sociology professor (and now provost) Teresa Sullivan have honed the approach of using written questionnaires and other survey methods in the personal bankruptcy context. With respect to medical problems, Professor Warren co-authored a paper with medical school professors David Himmelstein and Steffie Woolhandler and sociology professor Deborah Thorne that used data from the 2001 Consumer Bankruptcy Project studying filers in five states. One of the main data sources was written questionnaires, on which respondents could indicate whether they had out-of-pocket expenses of at least \$1,000 in the two years prior to bankruptcy, the uses of second mortgages, and whether they had health insurance. Respondents also could pick reasons for bankruptcy (including illness or injury) from a list of pre-coded options.<sup>69</sup> The 2001 CBP undertook follow-up telephone surveys with a subset of the filers that reviewed out-of-pocket costs and medical diagnoses in greater detail.<sup>70</sup> Ultimately, Himmelstein et al. concluded that nearly half of bankruptcies could be characterized as medical-related.<sup>71</sup> Other studies (including some authored or co-authored by one of us) have used the same data for analysis or adopted similar survey instruments for other datasets.<sup>72</sup>

Published in the peer-reviewed journal *Health Affairs* as a web exclusive, the Himmelstein paper was released in early 2005 just as Congress was restarting deliberations on a major bill to restrict bankruptcy relief. Senator Grassley, a sponsor of that bill, requested that a division of the Department of Justice (the Executive Office for United States Trustees) supply information to determine the validity of the Himmelstein findings. Assistant Attorney General William Moschella submitted a short letter and summary reporting the frequency and amounts of medical debt detectable in court records in a sample of no-asset chapter 7 cases. Those figures are reprinted in Table 1 in Part III; as noted in the introduction, the letter and summary suggested that the medical debt impact appeared modest. The letter closed by stating that “the conclusion that almost 50 percent of consumer bankruptcies are ‘medical related’

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<sup>68</sup>Most general population studies that include bankruptcy-related questions use self-reported information. See, e.g., Peter J. Cunningham, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families 2003-2007*, Ctr. for Studying Health System Change Tracking Report No. 21, p. 2 (Sept. 2008); USA Today/Kaiser Family Foundation/Harvard School of Public Health, *Health Care Costs Survey, Summary and Chartpack*, Chart 3 (Aug. 2005); Aparna Mathur, *Medical Bills and Bankruptcy Filings* (Am. Enterprise Inst. July 19, 2006).

<sup>69</sup>David Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, Health Aff. Web Exclusive, W5-67 (Feb. 2005).

<sup>70</sup>Himmelstein et al., *supra* note 69, at W5-69. Among the respondents who participated in telephone interviews and said they had medical reasons for bankruptcy, the average amount of out-of-pocket expense (excluding premiums) in the year leading to bankruptcy was over \$3,500. Out-of-pocket expense since illness onset averaged \$12,000. *Id.*

<sup>71</sup>Himmelstein et al. *supra* note 69, at W5-66.

<sup>72</sup>See, e.g., Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535 (2006); Ezekial Johnson & James Wright, *Are Mormons Bankrupting Utah? Evidence from the Bankruptcy Courts*, 40 SUFFOLK U. L. REV. 607 (2007) (replicating methods, 61% in Utah study reported that medical problems contributed to their bankruptcy filings); Sidney D. Watson et al., *Living in the Red: Medical Debt and Housing Security in Missouri* (The Access Project 2007).

requires a broad definition and *generally is not substantiated* by the official documents filed by debtors.”<sup>73</sup>

Assistant Attorney General Moschella’s observation is based on the following method: whether coders could find holders of claims that had demonstrably medical names on “Schedule F,” a list of claims that debtors must file with the court.<sup>74</sup> On Schedule F, debtors list the amount of non-priority unsecured claims owed at the time of filing and the identity of the holders of such claims at that time. The summary of findings attached to the letter correctly noted that this approach would not include bills owed on the date of bankruptcy to a creditor with a non-medical name, but the letter did not highlight the relevance of this limit.<sup>75</sup>

Court record studies of medical bills were not without precedent. Early studies of the bankruptcy system under the 1978 Bankruptcy Code relied broadly on court records for all sorts of queries.<sup>76</sup> Since then, researchers have identified pros and cons to using debtor-generated court records more generally.<sup>77</sup> As studies of bankruptcy filers have evolved and use of consumer credit use has grown substantially, so have the objections to the use of the records of unsecured claimants to measure medical burden.<sup>78</sup>

Nonetheless, certain U.S. senators essentially pronounced the DOJ response to be a definitive debunking of the finding that medical problems contributed to about half of the bankruptcies in the Health Affairs

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<sup>73</sup> Letter to Senator Grassley from William Moschella, Cong. Rec. S2078 (Mar. 4, 2005) (emphasis added). The letter characterized the Himmelstein et al. definitions of medical bankruptcy as “very broad” and highlighted that the article’s broader definition of medical bankruptcy included drug addiction and uncontrolled gambling although those factors were nominal additions to the overall count. [http://grassley.senate.gov/news/Article.cfm?customel\\_dataPageID\\_1502=12734#](http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=12734#) (Feb. 10, 2005).

<sup>74</sup> Official Forms, Schedule F: Creditors Holding Unsecured Nonpriority Claims, [http://www.uscourts.gov/rules/BK\\_Forms\\_1207/B\\_006F\\_1207f.pdf](http://www.uscourts.gov/rules/BK_Forms_1207/B_006F_1207f.pdf).

<sup>75</sup> Cong. Rec. S2078. After the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA) had been enacted, the Director of the United States Trustee Program was circumspect about what could be gleaned from Schedule F about medical burden. He observed that the Program did not have “definitive data” on the amount of medical debt owed by bankruptcy filers and that, even with data-enabled forms that the Program hoped to develop, medical debt would be difficult to measure through those forms. Clifford White Congressional Testimony at 4-5, Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy, pp. 4-5 (July 17, 2007). White’s testimony cited 2003 data in which 46% of the filers in no-asset chapter 7 cases included medical debt on Schedule F, about 78% of them reported debt less than \$5,000, and fewer than 1% of the cases represented more than one third of the total medical debt.

<sup>76</sup> TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, AS WE FORGIVE OUR DEBTORS (1989) (filers from 1981); Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L. J. 675 (1991) (filers from 1985-86).

<sup>77</sup> See, e.g., Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 383 (2001).

<sup>78</sup> See, e.g., Letter to Senator Kennedy from David Himmelstein, Teresa Sullivan, Elizabeth Warren, Steffie Woolhandler, Melissa Jacoby, Deborah Thorne, and Jay Westbrook, Cong. Rec. S6010 (May 26, 2005). This letter identified a list of debts that likely would be excluded from the analysis cited in the Moschella letter as well as the implications of including only no-asset chapter 7 cases.

paper. Senator Grassley issued a press release strongly suggesting that assertions of high percentages of medical-related bankruptcies were myth.<sup>79</sup> Senator Sessions used the DOJ study to suggest that the figures were fiction.<sup>80</sup>

Likewise, academic critics highlighted the DOJ findings and gave credence to the court record claim holder analysis as a valid useful measure of medical bill burden.<sup>81</sup> Within a lengthier critique making a variety of points about the Himmelstein study, two health care finance experts included a full paragraph discussing the DOJ findings as a counterpoint.<sup>82</sup> They used this and other studies to support the inference that medical debt is but a small proportion of the obligations facing those who file for bankruptcy.<sup>83</sup> In written testimony for a Congressional hearing on medical problems and bankruptcy that included a variety of other observations about the Himmelstein study, a law professor described and cited the DOJ

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<sup>79</sup> Senator Grassley said:

Make no mistake, misrepresentations about this legislation have been running rampant by those who oppose any meaningful bankruptcy reform. I've been in politics a long time, and I know that political criticism is never inhibited by ignorance. For example, the statistical analysis in the U.S. Trustee's office examined over 5000 bankruptcy cases and found that under one-half listed medical debts of any sort. And those filers who did list medical debts, on average, listed under \$5000 in medical debts. So much for the myth that most bankruptcies are driven [sic.] medical costs. The fact is that there are abusers out there. The fact is S. 256 doesn't harm bankrupts with large medical debts. Let's stop the abuse. Let's return to common sense. Let's enact bankruptcy reform now, before the abuse gets worse.

Press Release, Opening Statement of Senator Chuck Grassley at the Bankruptcy Reform Hearing (Feb. 10, 2005), available at [http://grassley.senate.gov/news/Article.cfm?customel\\_dataPageID\\_1502=9716](http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=9716).

<sup>80</sup> Senator Sessions said:

This is what the United States Trustee Program found in a much more extensive survey . . . They were asked to survey the filings in their districts to find out what you list on your filing as your debts, who you owe. You actually list who it is. So, if it is a doctor bill, it is on there. If you don't put it on there you don't wipe out that debt and you remain obligated to pay it, so everybody puts every debt they have on the list so it can be wiped out when they file bankruptcy. What they found was, this professional study of 5,000 cases, not interviewing debtors but looking at what they put on their form, they found that only slightly more than 5 percent of the total unsecured debt reported in those cases was medically related. Only 5 percent was medically related. This is not 50% of the cases in bankruptcy being caused by medical – only 5 percent of them, of the total debt, was medical . . . For some people there is no doubt that medical debts are a cause for bankruptcy. I do not doubt that. But this idea that we ought to assume that there is no fraud and abuse in bankruptcy and the idea that everybody is in bankruptcy because of medical debts is just not so. It is just not; it is a fiction. We need to get it out of our heads.

Cong. Rec. S2077 (Mar. 4, 2005). Senator Cornyn echoed the sentiments, saying "First, let me say to my friend, the Senator from Alabama, how much I appreciate his eloquence on this bill and his very successful attempt to explain to the American people, as well as to us, what is at stake here, and to knock down some myths that are being used to try to worry people when, in fact, there is no reason for people to be worried about this legislation." Cong. Rec. S2078 (Mar. 4, 2005).

<sup>81</sup> These writings also identified a range of other criticisms about the studies unrelated to the data source that are beyond the scope of this paper.

<sup>82</sup> David Dranove & Michael Millenson, *Medical Bankruptcy: Myth versus Fact*, Health Aff. Web Exclusive w78 (Feb. 2006) (citing DOJ study and conclusion without qualifications).

<sup>83</sup> *Id.*

findings for the proposition that only a few cases have sufficiently high medical debt to be properly characterized as a cause of bankruptcy.<sup>84</sup>

In 2009, interest in the scope of the medical bankruptcy problem has intensified. Very early in the year, then-President-Elect Obama's economic agenda included making it easier for people in medical-related bankruptcies to receive a discharge of debt.<sup>85</sup> Then, in the summer of 2009, Professors Himmelstein, Thorne, Warren and Woolhandler released a new study featuring an estimate that 62% of bankruptcy filers could be counted as medical-related.<sup>86</sup>

Most significantly, health care finance reform has focused the nation's attention on patient liability for medical bills. In late July 2009, the House Judiciary Committee called a hearing precisely to discuss whether the health care system is bankrupting American families. Representative Conyers cited the new Himmelstein study as evidence that health care finance reform is urgently needed.<sup>87</sup> But a witness at the hearing from the American Enterprise Institute cited the DOJ court record analysis, to which she referred as the "closest comparable study," to cast doubt on the survey-based findings.<sup>88</sup>

Although adherents to both methods continue to disagree, no one has systematically examined the differences between the measures and the consequences of the discrepancies. We undertake that here by using both data sources for a single population.

### *B. Data for the Current Study*

We analyze information from the 2007 Consumer Bankruptcy Project ("2007 CBP"), a nationally representative study of approximately 2,500 people and their partners, if any, who filed for bankruptcy in early 2007. This dataset was used in the recent Himmelstein paper. The response rate was 50%. Respondents and non-respondents shared similar characteristics on variables such as income, debt, assets, monthly expenses, and prior bankruptcies.<sup>89</sup> The dataset has a slight underrepresentation of chapter 13

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<sup>84</sup> Todd Zwycki Congressional testimony, Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy, pp. 8-9, 12 (July 17, 2007).

<sup>85</sup> See generally Sarah Rubenstein, *Obama Aims to Help Patients Wipe Away Medical Debts*, WALL ST. J., Jan. 7, 2009 (citing [http://change.gov/agenda/economy\\_agenda](http://change.gov/agenda/economy_agenda), which says "Obama and Biden will create an exemption in bankruptcy law for individuals who can prove they filed for bankruptcy because of medical expenses. This exemption will create a process that forgives the debt and lets the individuals get back on their feet.").

<sup>86</sup> David U. Himmelstein, Deborah Thorne, Elizabeth Warren, & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: The Results of a National Study*, 122 AM. J. MED. 741 (Aug. 2009).

<sup>87</sup> Rep. Conyers opening statement, July 28, 2009.

<sup>88</sup> Aparna Mathur AEI written testimony, July 28, 2009.

<sup>89</sup> Robert M. Lawless et al., *Did Bankruptcy Reform Fail? An Empirical Study of Consumer Debtors*, 82 AM. BANKR. L. J. 349, 391-397 (2008) (offering full discussion of methods of 2007 CBP).

cases, which we correct with weighting when necessary.<sup>90</sup> The median age of a filer in the 2007 CBP is 43, older than the median in the general population.<sup>91</sup> Median household income of the sample is less than \$28,000.<sup>92</sup> Median net worth is substantially negative (nearly -\$24,400).<sup>93</sup> About half were homeowners when they filed for bankruptcy, and among them, median mortgage debt was just over \$100,000.<sup>94</sup>

All respondents completed written questionnaires that included demographic information, as well as other information not routinely found in court records.<sup>95</sup> For all respondents, the 2007 CBP also extracted information on approximately 200 variables from court records, many of which are debtor-supplied under penalty of perjury. The 2007 CBP conducted follow-up telephone surveys with approximately 1,000 respondents within a year after they filed for bankruptcy.<sup>96</sup>

The instant project is unique in several respects. First, we specifically coded Schedule F medical debts to approximate the DOJ method of identifying medical debts.<sup>97</sup> Second, unlike in earlier survey studies, the 2007 CBP subdivided the “reasons for bankruptcy” questions so that filers could distinguish between medical bills and the other ways in which medical problems can contribute to financial distress, such as

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<sup>90</sup> The average Schedule F medical debt is significantly higher for chapter 7 filers than chapter 13 filers, but there was no chapter-related difference in the *likelihood* of reporting medical debt on Schedule F. In addition, the median Schedule F medical debt for chapter 7 and chapter 13 filers is not significantly different (\$1,698 for chapter 7 filers versus \$1,384 for chapter 13). Filers in the two chapters also had a similar distribution of Schedule F debts (as well as questionnaire expense) across the range, with the differences skewing the averages likely coming largely from the group of filers with Schedule F medical debts \$10,000 and above. Thus, for most of our analysis, we combine the two kinds of cases without weighting, but indicate where we have used weighting.

<sup>91</sup> Deborah Thorne, Elizabeth Warren & Teresa A Sullivan, *Generations of Struggle*, HARV. L. & POL’Y REV. (2009). The median age in the general population in 2007 was only 36.1. *Id.* at 3, Fig. 1.

<sup>92</sup> Lawless et al., *supra* note 89, at 359, 404. The mean was under \$31,000. *Id.* at 404. In terms of income distribution, about 85% of the 2007 CBP respondents had incomes below the U.S. national median household income in 2007 (undifferentiated by household size), and more than three in ten had incomes below the “poverty rate” for a family of four. For national median income figures, see Carmen DeNavas-Walt, Bernadette D. Proctor, & Jessica Smith, Current Population Reports: Income, Poverty, and Health Insurance in the United States: 2007, P60-235 (Aug. 2008), *available at* <http://www.census.gov/prod/2008pubs/p60-235.pdf>. For the poverty guidelines, see U.S. Dept. of Health & Human Services, 2006 Poverty Guidelines, *available at* <http://aspe.hhs.gov/POVERTY/06poverty.shtml>. The income distribution is shown in Lawless et al., *supra* note 89, at 360 fig. 2.

<sup>93</sup> Lawless et al., *supra* note 89, at 371, 405.

<sup>94</sup> Lawless et al., *supra* note 89, at 365.

<sup>95</sup> See Lawless et al., *supra* note 89, at 399-402 (reproducing questionnaire).

<sup>96</sup> See Lawless et al., *supra* note 89, at 396-97. As was previously noted, the telephone survey subsample is not significantly different from the whole regarding variables such as filing status, chapter, total assets, total debts, priority debts, monthly income, and home value.

<sup>97</sup> The specific codebook instruction was: “This number represents the sum of debts that appeared to be owed to medical providers. Debts were counted as medical debts if they were owed to hospitals, doctors, labs, nursing homes, and other treatment facilities, pharmacies, medical collection agencies, and anything else that looked related to health, medical, wellness, or sickness.” 2007 Consumer Bankruptcy Project Court Record Codebook p. 13 (last updated May 27, 2008) (on file with authors).

lost income.<sup>98</sup> Notably, for this paper, we are not seeking a comprehensive count of cases that could be construed as medical bankruptcies; Himmelstein et al. have just offered this in their paper. The explicit “medical bill reason” for bankruptcy helps identify filers who are likely to have some non-trivial obligation. If court records are a useful source of information about medical burden, we at least should be able to find evidence of substantial medical bills in the records of these respondents.

In addition, the written questionnaire posed a more detailed series of questions about out-of-pocket medical expense than prior survey studies. The questionnaire asked whether respondents were directly responsible for medical bills uncovered by insurance within the two years leading up to the bankruptcy filing.<sup>99</sup> Respondents who said “yes” were asked two new follow-up questions. They were asked:

“How did you, or a spouse or partner, pay for the medical bills or prescriptions that were not covered by insurance? Did you: Check all that apply: Pay with a cash, check, or debit card; Pay with a regular credit card; Pay with a medical credit card (such as CitiHealth Card, CareCredit, or MediCredit); Pay with money from a home equity loan or line of credit; Agree to a payment plan with the medical provider; Something else (please specify).”

This question helps us to scrutinize the likely reasons for the absence of a medical bill in the court records and offers a window into the management practices explored in Part II(A). For this paper, we report findings for all of the responses but primarily discuss the cash, credit card, and home equity loan options. A more in-depth evaluation of payment plans and “something else” will be reported in a separate paper. Also, whereas prior surveys asked only whether respondents had more than \$1,000 in expense, respondents in our study were asked to identify the amount of out-of-pocket within specified ranges: less than \$1,000, \$1,000-\$5,000, \$5,001-\$10,000, and more than \$10,000. This greater specificity not only facilitates a better analysis of medical burden for other projects, but offers a better source of comparison to court records.

### III. Analysis and Findings

We start by reporting Schedule F medical debt in the 2007 CBP sample. We do so in a parallel fashion to the data in the DOJ analysis. The left column of Table 1 replicates the information in the DOJ letter.

The middle column is our data but limited to no-asset chapter 7 cases (liquidation cases) to most closely

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<sup>98</sup> These limits are in addition to the inability of court record indications of medical debt to capture some of the biggest indirect costs such as lost income and opportunity that have been explored elsewhere and is largely beyond the scope of this paper. See Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 563 (2006).

<sup>99</sup> The exact language of question 18 is: “During the TWO years before the bankruptcy, were you, or a spouse or partner, FINANCIALLY responsible for ANY medical bills, INCLUDING prescription medication or co-payments, that were NOT covered by insurance” (emphasis in original). The question did not ask the respondent to indicate the specific source of the cost (doctor, hospital, prescription drugs, etc.).

match the DOJ sample. The right column is our full sample that also includes chapter 13 (repayment plan) cases.

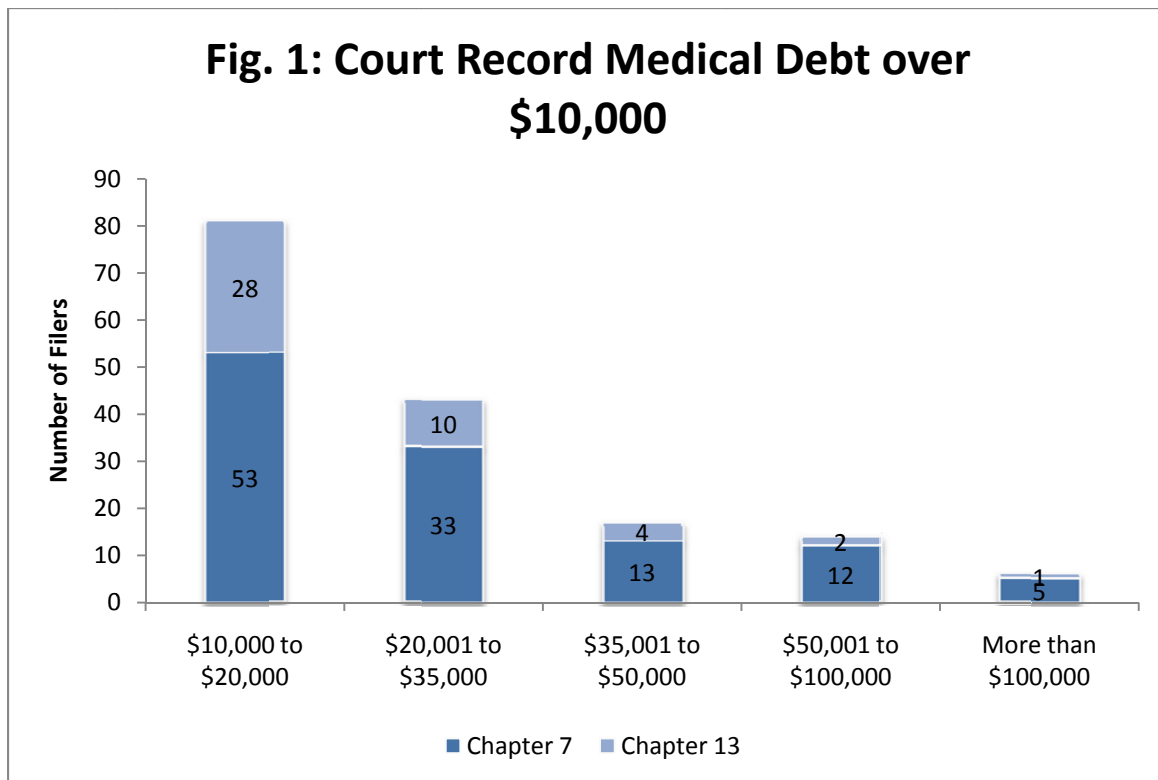
<b>Table 1: DOJ and 2007 CBP Sample Comparisons</b>		
<b>DOJ Sample (No-asset 7s closed between 2000 and 2002, excluding N. Carolina &amp; Ala.)</b>	<b>2007 CBP Sample (No-asset 7s Only)</b>	<b>2007 CBP Sample (7s and 13s)</b>
<i>All Cases</i>		
<i>N=5,203</i>	<i>N= 1,719</i>	<i>N=2,438</i>
<b>54%</b> listed no medical debt	<b>48.48%</b> listed no medical debt ( <b>50.6%</b> if including cases with missing data)	<b>49.84%</b> listed no medical debt ( <b>50%</b> if including cases with missing data).
Medical debt accounted for <b>5.5%</b> of the total general unsecured debt.	Medical debt accounted for <b>6.2%</b> of the total unsecured debt. (\$5,851,877 of \$93,095,955)	Medical debt accounted for <b>5.6%</b> of the total unsecured debt. (\$7,727,494 of \$136,353,023)
<b>90.1%</b> reported medical debts less than \$5,000	<b>86.2%</b> reported medical debts less than \$5,000 ( <b>88.6%</b> if cutoff inflation-adjusted to \$5,734).	<b>88%</b> reported medical debts less than \$5,000 ( <b>92.32%</b> with inflation-adjustment of cutoff)
<b>1%</b> of cases accounted for <b>36.5%</b> of medical debt.	<b>1%</b> of cases accounted for <b>37.3%</b> of all medical debt.	<b>1%</b> of cases accounted for <b>35.4%</b> of all medical debt.
Less than <b>10%</b> of all cases represent <b>80%</b> of all reported medical debt.	<b>10%</b> of all cases represent <b>80.3%</b> of all reported medical debt.	<b>10%</b> of all cases represent <b>79.8%</b> of all reported medical debt.
<i>Cases with any Schedule F Medical Debt</i>		
<i>N=2,391</i>	<i>N=853</i>	<i>N=1,271</i>
Among the debtors reporting medical debt, the average medical debt was <b>\$4,978</b> per case ( <b>\$5,709</b> in 2007 dollars)	Among the debtors reporting medical debt, the average medical debt was <b>\$7,483.20</b> per case.	Among the debtors reporting medical debt, the average medical debt was <b>\$6,313.30</b> per case (weighted by case type)
<b>78.4%</b> reported medical debts below \$5,000 (average of <b>\$1,212</b> for this group).	<b>73.4%</b> reported medical debt of less than \$5,000; <b>76.3%</b> with inflation adjustment (average of <b>\$1,405</b> for this group).	<b>76.12%</b> reported medical debt of less than \$5,000; <b>78.8%</b> with inflation adjustment (average of <b>\$1,394</b> for this group).
<b>21.6%</b> reported <b>80.9%</b> of the total medical debt.	<b>21.6%</b> of cases represent <b>82.4%</b> of the total medical debt. <sup>100</sup>	<b>21.6%</b> of cases represent <b>81.3%</b> of the total medical debt. <sup>101</sup>
Medical debts accounted for <b>13.0%</b> of the total general unsecured debt for those reporting medical debt.	Medical debts accounted for <b>12.3%</b> of the total general unsecured debt for those reporting medical debt.	Medical debts accounted for <b>12.2%</b> of the total general unsecured debt for those reporting medical debt.

<sup>100</sup> We do not know why the DOJ reported this measure, but we replicate it here. We also offer some other figures: 1% of cases account for 2.9% of the total medical debt, 10% of cases account for 67.4% of the total medical debt, and 20% of cases represent 81.4% of the total medical debt.

<sup>101</sup> Again, we offer more figures: 1% of cases account for 2.5% of the total medical debt, 10% of cases account for 65.3% of the total medical debt, and 20% of cases represent 80% of the total medical debt.

Overall, based on the measures reflected in the DOJ letter, our data are very close to the summary submitted to Senator Grassley. In other words, those who believe that the court record approach can debunk the survey approach could use our court record data.

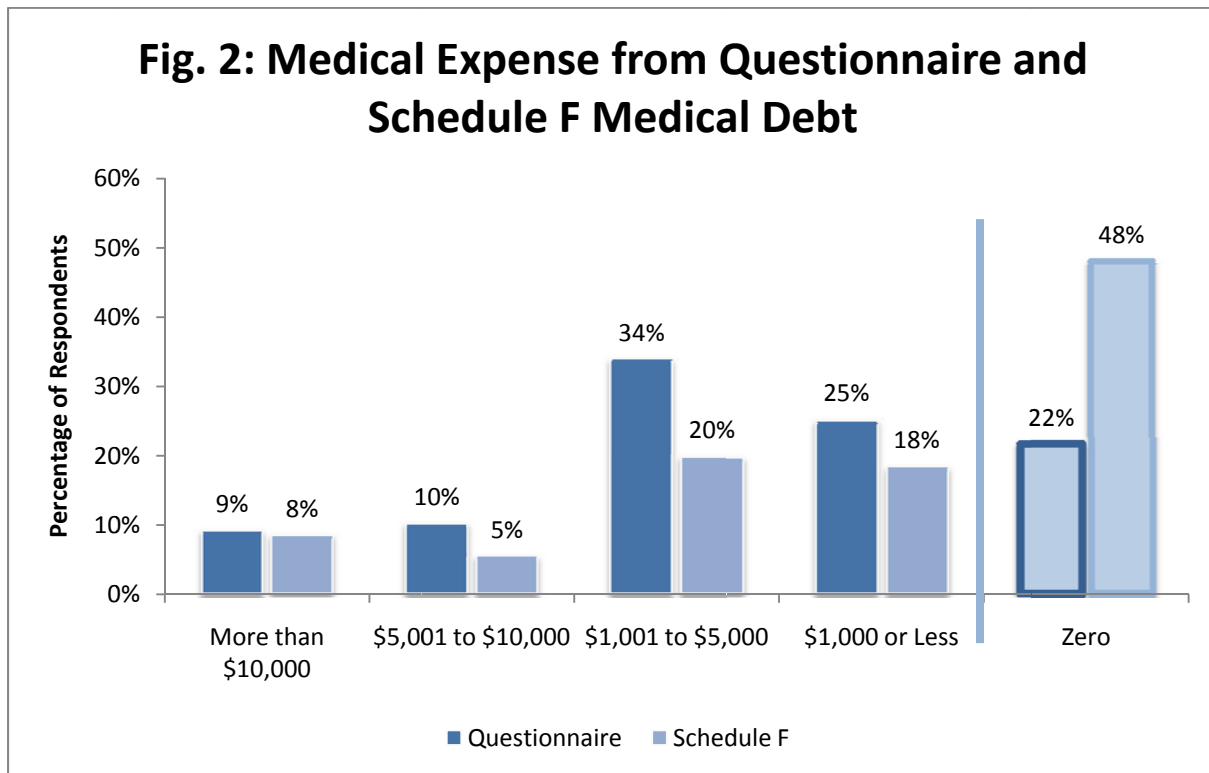
We do have a slightly greater proportion of cases than DOJ with some Schedule F medical debt, and our average medical debt is greater even after adjusting the numbers for inflation using the Consumer Price Index. In addition to these increases being consistent with rising medical costs (at a rate outpacing inflation generally) and self-pay obligation during the 2000s, the DOJ analysis reported neither median debt nor a distribution of the larger debts. Thus, it remains possible that differences in a small number of enormous debts are skewing the sample.<sup>102</sup> In Figure 1, we report the distribution of the 8% of our sample with more than \$10,000 in Schedule F medical debt to offer a glimpse of how higher-debt respondents may affect the average, subdivided by chapter of bankruptcy filing.<sup>103</sup>



<sup>102</sup>We did not cap or remove outliers (disclosed in Figure 1 and footnotes) because we have found no evidence that the data in the DOJ report capped or excluded outliers. Earlier analyses by U.S. Trustee researchers appear to include the biggest Schedule F medical debts. See Ed Flynn & Gordon Bermant, *The Class of 2000*, AM. BANKR. INST. J., Oct. 2001, at 20 (reporting that averages are being skewed by a small number of huge debts).

<sup>103</sup>Of the filers with Schedule F medical debts over \$100,000, four were just over this amount. Two had over \$500,000. Three of these six filers were under twenty-five years old.

Now that we have verified the similarities between our sample and the DOJ analysis, we move on to the question of how well this measure reflects pre-bankruptcy out-of-pocket expense. To be included in a Schedule F count, a medical bill must have several qualities. It must be outstanding on the date of the bankruptcy filing. The filer must know about the bill to report it. Also, the holder of the claim must be identifiable as medical to a third-party coder. Figure 2 displays the distribution of cases for two medical bill measures: it compares the distribution of Schedule F medical debt to the categorical amounts that respondents reported on the questionnaire.<sup>104</sup> Bear in mind that the questionnaire asked only about expense within two years prior to filing, whereas the percentage of cases with some Schedule F medical debt includes claims incurred at any time before filing. This comparison thus suppresses even greater potential differences between the measures.



As Figure 2 shows, we find consistently lower levels of Schedule F medical debt than out-of-pocket expense incurred within two years prior to filing.<sup>105</sup> Looking at the darker columns on Figure 2 that represent the questionnaire responses, we see that nearly eight of ten respondents reported *some* out-of-

<sup>104</sup> When we discuss “categories” of medical expense, we are referring to these categories: 0 = no debt, 1 = \$1,000 or less in debt, 2 = \$1,001 to \$5,000, 3 = \$5,001 to \$10,000 and 4 = more than \$10,000.

<sup>105</sup> As illustrated by Figure 1, the pattern from each data source is different. Written questionnaire expense forms a unimodal distribution, with a peak at \$1,001 to \$5,000. Schedule F medical debt manifests a different pattern, with about half the respondents having zero Schedule F medical debt, and well more than eight out of ten reporting \$5,000 or less.

pocket expense within two years before filing, whereas only about five of ten respondents had medical debt in the court records.

We examined the level of congruence between the court record and questionnaire measures in various and independent respects. We established the Cronbach's alpha between the two variables, which is 0.609.<sup>106</sup> This level of correlation between the two measures is low enough to merit concern about the validity of using one of these measures as a stand-in for the other.<sup>107</sup>

Next, we engaged in a filer-by-filer comparison of expense. First, we simply matched up each filer and compared the dollar value of the two measures. Doing this, we identified about a third of respondents in our sample (32%) that reported expense on the questionnaire but had no Schedule F medical debt.

Documenting precise declines in dollar amounts when neither number is zero is more difficult because the questionnaire variable is categorical, but we conservatively estimate that an additional 56% of the sample had less Schedule F medical debt than questionnaire-reported expense.<sup>108</sup>

Our second filer-by-filer approach was to subtract the categorized measure of Schedule F medical debt from the questionnaire expense figures for each respondent.<sup>109</sup> For each case, this gave us a nine-point scale ranging from -4 (individual had more than \$10,000 in Schedule F medical debt and no out-of-pocket

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<sup>106</sup> Cronbach's alpha is a measurement of how well two or more variables "hang together" or whether they measure a single latent construct, and is a measure of the reliability or consistency between the items at hand. It is computed through the equation:  $\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N-1) \cdot \bar{c}}$ , where N is the number of items,  $\bar{c}$  is the interitem covariance, and  $\bar{v}$  is the average variance of the items. At the most basic level, Cronbach's alpha allows a researcher to evaluate how well one variable can replace another variable.

<sup>107</sup> Generally, for comparing groups, a Cronbach's alpha of .70 to .80 or higher is considered acceptable. J. Martin Bland & Douglas G. Altman, *Statistics notes: Cronbach's alpha*, *BMJ*, Feb. 22, 1997.

<sup>108</sup> To calculate the differences between questionnaire-reported medical expense and Schedule F medical debt for this particular finding, we subtracted each individual's reported expense from Schedule F medical debt, allowing us to compare the two reporting processes in a "pair-wise" manner. We needed to estimate a dollar amount for expense because the questionnaire asked only for bracketed estimates. To estimate, we took the middle point of each expense category and used that to calculate the difference. For example, for the category \$1,001 to \$5,000, each respondent that indicated that expense fell into this group was assigned a dollar debt amount of \$3,500.50. For those who reported "more than \$10,000" in expense, we assigned them a dollar amount of \$15,000 for purposes of this analysis. We believe this to be a particularly conservative estimate, given that on Schedule F, only half of the medical debts over \$10,000 were also under \$20,000. See Figure 1. To prevent these respondents from skewing the average difference between the two responses, we coded anyone who reported "more than \$10,000" in debt and reported more than \$10,000 in debt on Schedule F as having zero difference between their filings and their survey response. Again, this allows our measure to be conservative.

<sup>109</sup> The initial categories of expense, consistent with the ranges on the questionnaire, are coded as follows: zero means no expense, a 1 means under \$1000, a 2 represents expense between \$1,000 and \$5,000, a "3" means expense between \$5,001 and \$10,000, and a 4 represents more than \$10,000. Subtracting the category of Schedule F debt from the category of questionnaire expense indicated by each respondent yields the number between "-4" and "+4." These numbers thus take on a meaning different from the original codes. For example, a "zero" indicates the same category of expense on both measures, whether that category is no medical bills or over \$10,000 in medical bills. When we use numbers in the appendices and going forward, we are referring to the result of this subtraction.

medical expense reported on the questionnaire) to +4 (more than \$10,000 in expense on the questionnaire but reported no Schedule F medical debt). Appendix A shows the distribution of cases along this scale.

Most people had either the same category of expense on both measures or more expense on the questionnaire than on Schedule F.<sup>110</sup> About one-fifth of the sample clearly had at least \$1,000 greater out-of-pocket expense than Schedule F medical debt, and often the minimum threshold was much higher, such as \$5,000 or \$10,000.<sup>111</sup> Cases with this extent of decline in medical bill magnitude pose the biggest challenge to using court records to measure medical burden. But they also present the most interesting questions of how these households managed to reduce these obligations in the midst of financial problems.

Although we will focus our additional tests on this fifth of respondents when we utilize the congruence scale, we must emphasize that this is not a comprehensive count of people with serious medical burden. Some respondents with significant medical bills do not have verifiable large discrepancies between the two measures. For example, the most populous group of filers whose expenses fall within the same category on both measures – and thus a “zero” – is very diverse in amounts of medical debt. For example, 11% of all respondents who are a “zero” had over \$10,000 of expense in both the questionnaire and Schedule F. Such a respondent may have owed, say, \$50,000 in medical bills beforehand and yet have \$10,050 in Schedule F medical debt. An additional 4% had between \$5,000 and \$10,000 of medical expense on both measures.<sup>112</sup> The average Schedule F medical debt for this group is just under \$5,000, suggesting that individuals could, in fact, have paid thousands of dollars towards their medical debt while

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<sup>110</sup> In the group of cases on the negative side of the scale, Schedule F medical debt exceeded the questionnaire reports of expense. We strongly suspect that these cases can be explained by the timing: the questionnaire asked for out-of-pocket expense only within the two years prior to filing. By contrast, Schedule F requires reporting of all lawfully collectible unsecured claims and thus captures debts older than two years. Some particularly big debts are likely to fit that pattern. Notably, the presence of some cases with Schedule F debt older than two years and no recent out-of-pocket expense slightly dampens the discrepancy between these two measures of medical burden. A small number of such cases may not only raise the Schedule F medical debt averages, but make the highest dollar category of medical bills (see Figure 2) seem more consistent across measures than it really is. Although we believe this to be the dominant explanation, particularly for the cases in the -4 and -3 categories, we offer several others as well. While completing the exact dollar amounts on Schedule F, respondents may have been more likely to have been consulting direct documentation and to be completing the paperwork with a lawyer. A debtor who estimated even a few dollars less on the questionnaire could create a discrepancy when Schedule F was subtracted. Most discrepancies on the negative side of the scale are within a one or two point difference, and thus potentially are of smaller amounts. Also, some medical providers impose interest and/or finance charges. A respondent may have recalled and reported only principal on the questionnaire, while Schedule F lists the legally collectible debt that includes these additional amounts. Finally, although the coding error rate in this study was exceedingly small, error remains a possible explanation. For the rate, see the appendix in Lawless et al., *supra* note 89.

<sup>111</sup> We refer here to categories “+2,” “+3” and “+4” which represent having at least \$1,000 more, \$5,000 more, or \$10,000 more in out-of-pocket expense than in Schedule F medical debt. The 20% figure is premised on missing variables being included in the total count. See Appendix A.

<sup>112</sup> Four in ten of those who are “zeros” because they fall within the same category on both measures had no Schedule F medical debt or out-of-pocket medical expenses within two years.

still occupying the same category of expense on the two measures. Cases that are a single category difference (a “+1” in Appendix A) between the court record and questionnaire measures also mask a wide range of dollar differences and significant medical obligations.<sup>113</sup> Although we report all of our results in the appendices, our discussion reports primarily those with verifiably greater categories of expense than Schedule F medical debt.

The lack of Schedule F medical debt or a significant decline in amount could be attributable to a variety of explanations that we can explore, beyond the standard problem that some medical providers may not have medical-sounding identities that court record coders can discern.<sup>114</sup> First, having more questionnaire-reported medical expenses than Schedule F medical debt could reflect that individuals on the brink of bankruptcy paid off some or all of their medical bills. Even if this were the case, such payoff would not necessarily signify a lack of financial burden from the bills; money is fungible and financially distressed families constantly make difficult choices about how to juggle expenses. Those filers most concerned with maintaining relationships with doctors could have fought very hard to pay these expenses while defaulting on other major obligations, or shifting other obligations to credit cards. It also is possible that providers gave respondents significant discounts for prompt payment that remain invisible to us, although those payments could have come from another credit source. We can test the payoff hypothesis by looking at how the filers report managing their medical expenses, with careful attention paid to the reported use of cash or cash equivalents.

In addition, some existing medical bills might simply be missing from Schedule F. This could be due to inadvertence,<sup>115</sup> a mistaken belief that insurance would fully cover a pre-bankruptcy procedure,<sup>116</sup> or a more intentional effort to hide the fact of the bankruptcy from a provider (who, if not listed, may not hear about the case) to avoid a feared disruption in medical services.<sup>117</sup> The possibility of these circumstances

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<sup>113</sup> Those respondents that fall in the “+1” category have, on average, just under \$1,000 in Schedule F medical debt and are most likely to report less than \$1,000 in out-of-pocket costs in the two years prior to filing. However, like the “zeros,” these individuals could easily have large differences in the amount of expense and Schedule F medical debt. For example, some respondents indicated more than \$10,000 in expense and reported between \$9,000 and \$10,000 in medical debt on Schedule F. It is possible that they had \$10,001 in expenses and only paid off \$100 of that debt, putting them in one category lower, but it also is possible that respondents had \$25,000 in expenses and paid \$15,100 off those expenses off prior to bankruptcy.

<sup>114</sup> See *infra* note 137.

<sup>115</sup> See, e.g., *In re Hocum*, 119 B.R. 723 (Bankr. D. S.D. 1990) (granting debtor’s post-discharge request to amend Schedule F to include accidentally omitted \$262.94 hospital bill that had been assigned to debt collector).

<sup>116</sup> For example, in one case, the debtor originally failed to list medical debt on Schedule F because he thought Medicare would fully cover his cataract operation. He amended Schedule F once he realized his error. *In re Nosler*, 2007 WL 4322315 (Bankr. M.D. Fla. Aug. 2, 2007).

<sup>117</sup> See Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 383 (2001). As explained earlier, medical debts to providers with non-medical identities will escape detection under the DOJ coding method.

explaining the complete disappearance of a medical bill can be explored in part by looking at cases in which complete payoff would be most unlikely due to the size of the bills.

As the literature review suggested, reporting more expense on the questionnaire than medical debt on Schedule F also could be due to the use of a credit card, home equity loan, or less formal borrowing to finance part or all of medical bills. In such an instance, out-of-pocket medical expense, even if not paid fully by the time of filing bankruptcy, would not appear as Schedule F medical debt. Or, if Schedule F medical debt did appear, it would be lower in amount, while debt to other creditors would likely be higher.

Also, discrepancies between court record and survey approaches could reflect that people overmedicalize their financial problems on questionnaires. As a general proposition, we recognize the risk.<sup>118</sup> But we think that it is unlikely to be the explanation for the discrepancy in this particular study because of the methods we are employing. The discrepancy reflected in Figure 2 and the text is based on a purely factual question about out-of-pocket obligation not covered by insurance. By refraining from using the term “medical debt,” which could be susceptible to multiple interpretations, that variable becomes additionally straightforward. In addition, when respondents were asked to indicate their reasons for filing – the place where overmedicalization would be most suspected – they did not merely check every available reason for filing that might be sympathetic. Indeed, only three out of ten respondents explicitly indicated medical bills as a reason for bankruptcy even though far more reported out-of-pocket medical expense and had other indicators of distress.<sup>119</sup> We employ the “medical bill reason” variable as another clue as to whether respondents had some nontrivial medical liability rather than for the causal nature of the claim. Even skeptics of survey studies would be unlikely to suggest that people who said medical bills were a reason for bankruptcy lacked any medical liability.

To begin our assessment of these possibilities, we look at the raw percentages on use of cash, credit cards and home equity loans for people with any medical expense not covered by insurance.<sup>120</sup> These absolute percentages of generic formal credit usage presumably are dampened by the proximity to bankruptcy,

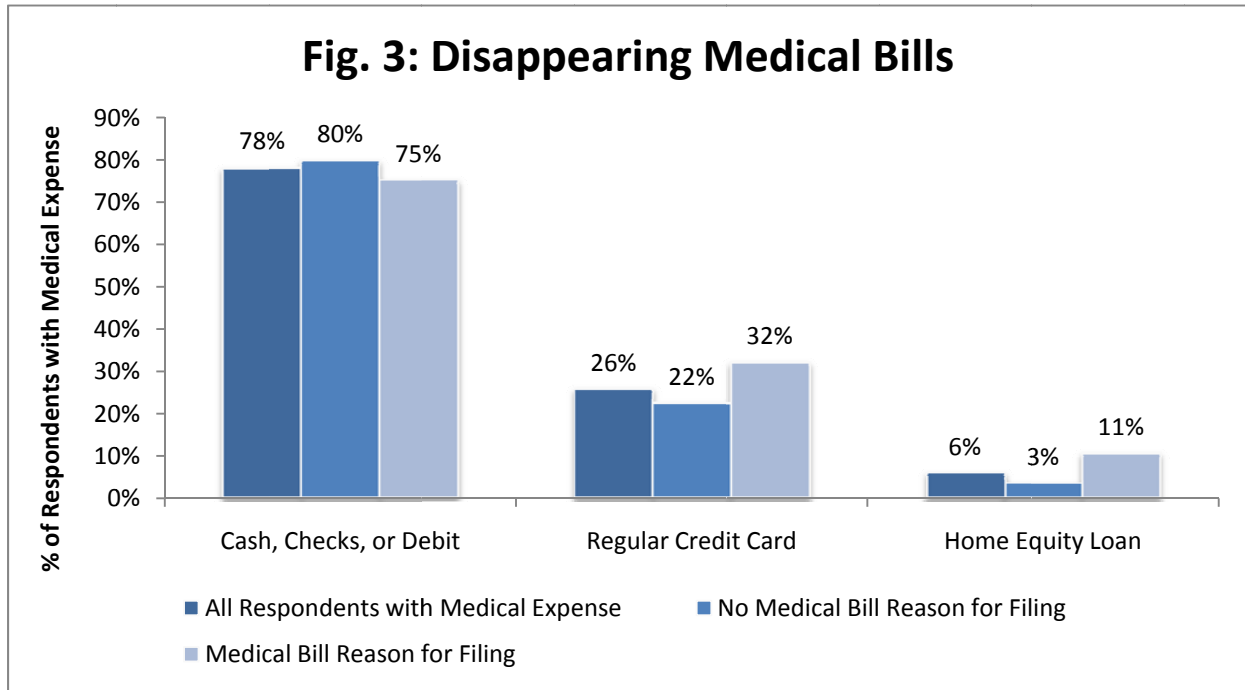
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<sup>118</sup> In prior papers, one of us has observed that some filers undermedicalize their financial reasons. Jacoby & Warren (2006). *See also* Jacoby, Sullivan and Warren (2001) for discussions of overmedicalization generally.

<sup>119</sup> Respondents in our sample selected an average of 4.33 reasons for filing out of a total of 19. Respondents that included the medical bill reason had a slightly higher average (5.75) but this can be explained by the fact that there was a strong association between reporting medical bills as a reason and the other medical reasons on the list of responses. For more information about the indication of medical reasons for filing, see *infra* Figure 6.

<sup>120</sup> The numbers in figure 3 may be slightly different from those in Appendix B because there were fewer missing data points when looking only at this variable on the questionnaire rather than in combination with court records. Also, Appendix B shows the difference in home equity use percentages if one includes all who reported expense regardless of housing tenure.

suggesting that some filers already had consumed their available credit.<sup>121</sup> But overall frequency is less important than the circumstances under which respondents used credit. Thus, for example, respondents who reported medical bills as a reason for bankruptcy reported with much greater frequency using third-party credit sources such as regular credit cards and home equity loans that are undetectable using the DOJ court record methodology.



Among those respondents with some medical expense in the two years prior to filing, those who report medical bills as a reason for bankruptcy use home equity for medical bills nearly four times as much as the other respondents, and have a higher rate, by nearly a third, of using credit cards.<sup>122</sup>

<sup>121</sup> We do not know the credit limits of our respondents. Because credit limits are not regularly reported in the general population, studies have used various techniques to estimate them. See ROBERT B. AVERY ET AL., AN OVERVIEW OF CONSUMER DATA AND CREDIT REPORTING, FED. RES. BULL. 58 (Feb. 2003), available at <http://www.federalreserve.gov/pubs/bulletin/2003/0203lead.pdf>. The most common approach is to use the highest balance ever reported as the credit limit. Using this technique, Avery et al. found in their 2003 paper that about 25% of revolving accounts in the general population had a credit limit below \$1,000; 41% had a credit limit between \$1,000 and \$5,000; and only a very small percentage had a credit limit of \$25,000 or more. *Id.* Looking at the overall profile of revolving accounts, the average credit limit was about \$4,500. *Id.*

<sup>122</sup> Differences between those with a medical bill reason for filing and those without a medical bill reason for filing are statistically significant for use of credit cards and home equity loans to the 0.05 level. All differences, when tested across the three groups (all respondents with medical expenses, those with a medical bill reason for filing, and those without a medical bill reason for filing), are statistically significant with an ANOVA test. However, we cannot identify which of the differences are causing that statistical significance.

We also examined the congruence between levels of questionnaire medical expense and Schedule F medical debt depending on whether or not respondents listed a medical bill reason for bankruptcy. Respondents who listed medical bills as a reason for filing for bankruptcy have, on average, twice the difference between medical expenses and Schedule F medical debt as those who do not identify medical bills as a reason for filing.<sup>123</sup> And, as noted in the introduction, over a quarter (27%) of those who identify a medical bill reason for bankruptcy have zero Schedule F medical debt.

To explore further the possible explanations for reduced medical debt in Schedule F, we look at medical bill management of respondents with various levels of discrepancy between questionnaire expense and Schedule F medical debt. Appendix B reports all of our results as well as whether the differences are statistically significant using a traditional ANOVA test.<sup>124</sup> Figure 4 shows three important methods of responding to medical bills. It reports these in groups that had increasing amounts of difference between Schedule F medical debt and reported out-of-pocket expense. If paying off medical bills in full were the explanation for the decline or disappearance of medical bills by the time of bankruptcy, we would expect to see high rates of reporting use of cash and cash equivalents by groups of respondents with the biggest gaps. But the frequency of cash or cash equivalents to pay some portion of medical bills remains largely consistent throughout the scale. On Figure 4 and in Appendix B, we see a pattern of decreasing use of cash, with the lowest frequency of cash usage reported by those who reported \$10,000 or more expense on the questionnaire and no Schedule F medical debt.<sup>125</sup> This suggests that having lower Schedule F medical debt is not simply due to individuals easily, or not so easily, paying off medical bills completely with cash, debit cards, or checks before filing.

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<sup>123</sup> The difference is statistically significant. Overall, all respondents report just over half of a category more of medical expense than of medical debt; those who list medical bills as a reason for filing have, on average, approximately three-quarters of a category more of medical expense than medical bills, while those who did not indicate that medical bills were a reason for filing have less than 0.4 of a category more medical expense than Schedule F medical debt.

<sup>124</sup> As these variables are coded as “Yes” or “No” variables, the frequency can be essentially understood as the percent of respondents in the group replying affirmatively to the question.

<sup>125</sup> The difference in use of cash, debit cards and checks is statistically significant to the 0.002 level. Using the ANOVA method of testing the differences in the groups does not allow us to identify *which* differences are statistically significant, but does allow us to demonstrate that the overall patterns of use vary enough to be statistically significant.

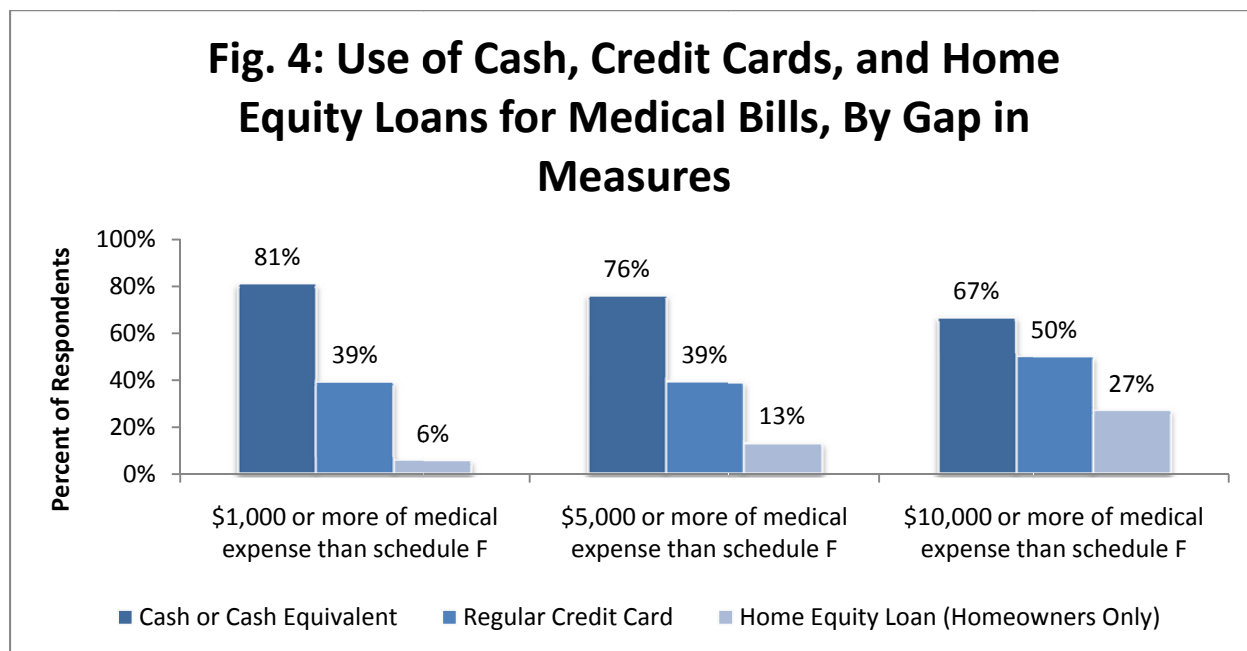


Figure 4 illustrates a positive relationship between the reported use of a regular credit card to pay medical bills and the difference between reported expense on the questionnaire and Schedule F medical debt.<sup>126</sup> Those debts become minimized or invisible in studies that rely exclusively on coding medical-sounding claim holders from Schedule F in the court records.<sup>127</sup>

With respect to home equity loans, those with significantly greater amounts of out-of-pocket expense than Schedule F medical debt report use of home equity loans with much greater frequency.<sup>128</sup> This is especially true if we look at those with at least \$10,000 or more in expense reported on the questionnaire than Schedule F medical debt; more than a quarter of this group used home equity loans to pay medical

<sup>126</sup> The differences in use of a regular credit card for medical bills are statistically significant to the 0.000 level. Like anyone reporting medical expense on the questionnaire, the group that reported \$10,000 of debt on Schedule F and zero expense on the questionnaire would have skipped the question about managing out-of-pocket expense and thus had the “lowest” use of all methods of payment.

<sup>127</sup> As another measure, when we isolated and compared the Schedule F medical debt of those who indicated using credit cards for medical bills from those who did not so indicate, the credit card users reported lower average and median medical debts, but had nearly twice the amount of credit card debt. The figures were \$5,264 average Schedule F medical debt for credit card users versus \$6,841 for non-users. We also compared medians: those who used credit cards to pay medical bills had a median Schedule F medical debt of \$1,473, compared to \$1,791 for those that did not use a credit card. The difference is significant to the 0.05 level. Those that reported using a regular credit card to pay for medical expenses filed, on average, \$31,853 in credit card debt on Schedule F, compared to \$15,792 in credit card debt for those that did not use a regular credit card to pay medical expenses.

<sup>128</sup> Figure 4 portrays the percentages of those that owned a home that used a home equity loan for medical expenses; if we look at all filers (not just those that owned a home in the last five years) we see a similar pattern, but smaller numbers. For example, 19% of those in the highest group report using a home equity loan, compared to 3% of those reporting the same amount on both measures. The differences exhibited using either methods of measurement are statistically significant to the 0.0001 level. All data on the individual breakdown of use of home equity loans are available in Appendix B.

debts. This is in sharp contrast to the overall rate of 5.8% who used a home equity loan to pay off medical debt among all homeowners in our sample.

Appendix C displays the comparative medical bill management for the group of respondents with \$10,000 or more expense reported on the questionnaire and zero Schedule F medical debt. This group is small, but we highlight it because of the significant amount of effort that would have been required to pay off \$10,000 -- or much more -- completely in cash within two years prior to filing for bankruptcy. Also, this biggest of possible differences between the measures would be the least likely to be due to forgetfulness about dollar amounts of medical bills, partial payoff of medical bills, seeking to hide their bankruptcy cases from providers, or other such explanations. Those with the highest level of expense on the questionnaire but zero Schedule F medical debt report using home equity loans for medical bills at over four times the frequency of everyone else, and report using credit cards twice as often as everyone else. Generally, filers with the greatest amounts of out-of-pocket expense but zero Schedule F medical debt had a much higher rate of shifting obligations to alternate creditors that court record coders could not detect as medical, as opposed to complete payoff or hiding the bills from their providers.

To further corroborate these findings, we looked at the amount reported on Schedule F of claims owed to *credit card* lenders (as opposed to claim holders with medical identities).<sup>129</sup> As Figure 5 shows, and is reported more fully in Appendix D, the amount of Schedule F credit card debt grows as the category difference increases between questionnaire-reported expense and Schedule F medical debt.<sup>130</sup> The filers represented in Figure 5 – all of whom had significantly higher out-of-pocket expense than Schedule F medical debt – had much higher average credit card debts than the \$19,006 average credit card debt of all filers in the sample, and also had higher median credit card debts than the overall median of the sample.

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<sup>129</sup> It can be difficult to identify credit card debt because of the variety of ways debt can be listed on Schedule F. Although we would get the same results either way as the next footnote explains, we used a very conservative, lower bound definition of credit card debt by using only debt in which the listing contained the words “credit card,” “card,” “revolving credit,” “charge account,” or closely similar terms. Also, any listing that contained brand name words for a credit card such as “Visa,” “MasterCard,” or “Discover” was counted as *definitely* credit card debt. See 2007 Consumer Bankruptcy Project Court Record Code Book (on file with authors).

<sup>130</sup> This result is obtained with the “definitely credit card” variable, but the same pattern emerged when we conducted the same analysis with the “probably credit card” variable, as well as with the two measures combined.

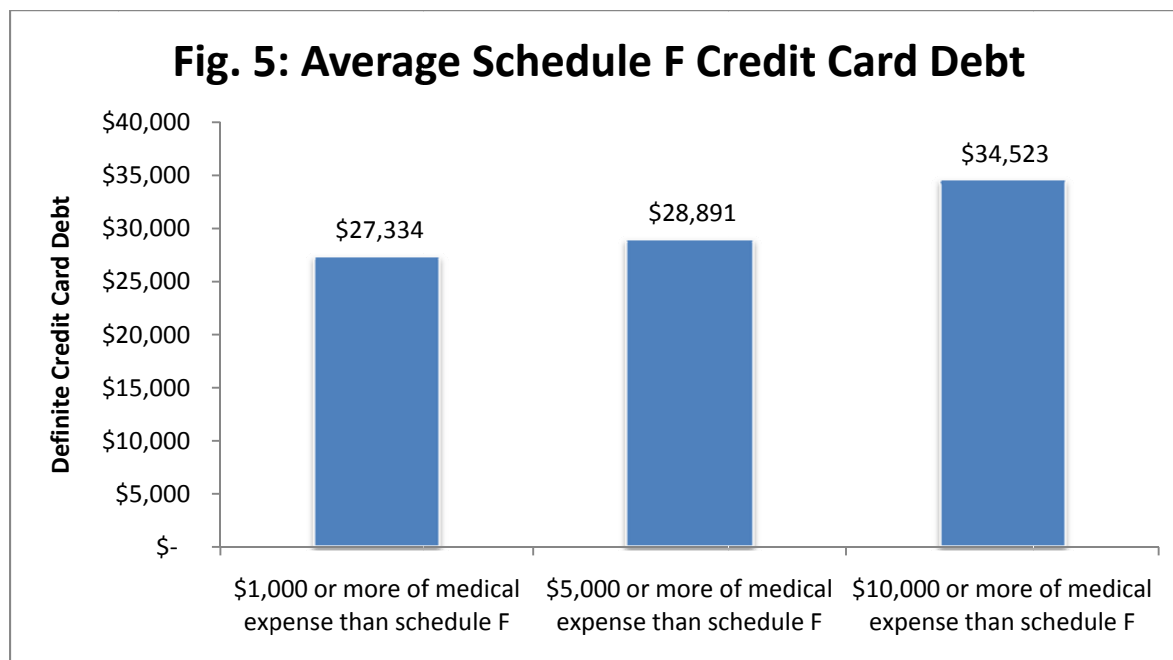


Figure 5 is consistent with the idea that those reporting more expense than Schedule F medical debt are not necessarily paying off this debt with ease, but rather are shifting their medical bills to alternate forms of credit.<sup>131</sup> These findings are also consistent with the story that bankruptcy filers in our sample are putting a higher priority on paying their medical bills over other types of bills. As money is fungible, these individuals go into bankruptcy with lower medical debt but higher levels of credit card debt. These results are also consistent with an earlier analysis of no-asset chapter 7 cases by researchers at the Executive Office for United States Trustees (in DOJ), in which Schedule F credit card debt levels were particularly high among filers with no observable medical debts on Schedule F.<sup>132</sup> We see similar patterns when we look at the amounts of secured claims against filers' residences.<sup>133</sup>

We explored other indicators that might shed light on why medical expenses are not appearing on Schedule F in full force. The 2007 CBP questionnaire asked respondents to indicate whether they

<sup>131</sup> The pattern is the same for both chapter 7 and 13 cases, but the amounts in chapter 7 cases are higher for all other than the cases fitting the column on the rightmost side of the figure.

<sup>132</sup> Ed Flynn & Gordon Bermant, *Credit Card Debt in Chapter 7 Cases*, AM BANKR. INST. J., Jan. 2004, at 20 (credit card debt of those with no Schedule F medical debt was higher than those with Schedule F medical debt and "was more than twice as high as for debtors who listed at least \$5,000 in medical debt."). See also *Seeing Red: The Growing Burden of Medical Bills and Debt Faced By U.S. Families*, The Commonwealth Fund, New York, NY (Aug. 2008).

<sup>133</sup> Looking at home owners only, we see that those with the highest level of difference between medical expenses and Schedule F medical debt also have the highest level of secured claims against their residence, a number which declines as the difference between medical expenses and Schedule F medical debt grows smaller.

engaged in a variety of methods to “make ends meet” during the previous two years.<sup>134</sup> We were interested in whether respondents with increasingly greater questionnaire-reported expense than Schedule F medical debt were more likely to report “Consolidated debts with a credit card or new loan” or “Put necessities on the credit card (for example, food or monthly bills)” as coping options. As Appendix E shows, those with higher expense than Schedule F medical debt were more likely to say that they put necessities on the credit card, although they were not necessarily more likely to say that they consolidated debt on a credit card or new loan.<sup>135</sup>

Finally, we turn back to filers’ stated reasons for bankruptcy disaggregated by discrepancies between the two expense measures. This helps determine the consequences of relying exclusively on Schedule F medical debt to measure medical-related financial burden. As Figure 6 shows and Appendix F reports more fully, as the gap between the measures grows, so does the percent indicating medical bills as a reason for filing for bankruptcy (the left-most column in each grouping). This suggests that Schedule F under-represents the magnitude of medical bill problems in the cases in which those bills mattered most from filers’ perspectives.

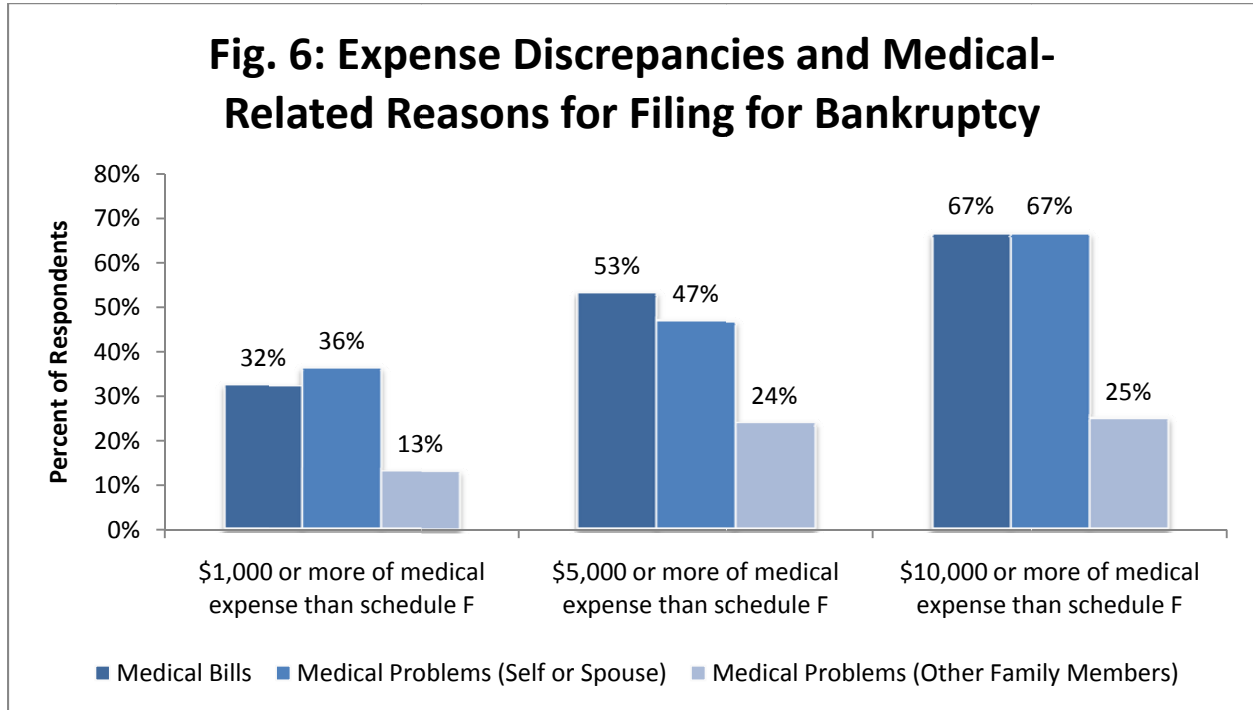
When we look at the group with the biggest gap (\$10,000 or more of expense, no Schedule F medical debt), the rate of reporting that medical bills contributed to the bankruptcy filing more than doubles the overall rate (67% versus 29%). Had we conducted our study relying entirely on court records, our medical debt count would not have included a single member of this group.<sup>136</sup> For the other respondents represented on Figure 6, a study relying exclusively on Schedule F would have significantly understated their medical burden.

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<sup>134</sup> The questionnaire asked: “During the TWO years before the bankruptcy, did EITHER you or a spouse or partner DO, or TRY TO DO, any of the following things in order to make ends meet? (Check all that apply.)” Possible responses were: “Worked more hours or got another job; Cashed out or borrowed from a retirement, a 401k, a pension account or life insurance; Refinanced your home, took out a home equity loan or line of credit, or took out a debt consolidation loan that was secured by your home; Sold your house; Asked creditors, such as landlords or credit card companies, to work with you on the payments; Sold or pawned a car, furniture, or other personal property; Consolidated debts with a credit card or new loan; Used a payday loan business (for example, Check to Cash) or car title lender to borrow money or take a cash advance; Put necessities on the credit card (for example, food or monthly bills); Accepted or borrowed money from family or friends; Accepted or borrowed money from a religious group or charity; or Something else.”

<sup>135</sup> It is not obvious that respondents would conceptualize moving medical bills to credit cards as a consolidation.

<sup>136</sup> The same pattern holds for illness of self or partner as a reason for filing. The group that indicated that familial medical bills were a cause of bankruptcy was generally smaller, but show similar patterns: 25% of the group with the highest level of difference between medical expenses (as reported on the questionnaire) and Schedule F medical debt choose this option, compared to 10.7% of the sample population.



The analysis for this project has limits. First, any attempt to code medical debts from court records risks the omission of providers or related parties with no obvious health care designation in its name; our study is no exception.<sup>137</sup> This merely reinforces the preference for multi-instrument studies over exclusive reliance on court records that our study ultimately supports. Second, the 2007 CBP questionnaire did not ask respondents to identify the precise type of health care they received. We thus cannot correlate type of care with type of medical bill management for the full sample as some readers have suggested would be useful.<sup>138</sup> Third, the nature of the data collection ultimately required that we compare a continuous variable (Schedule F medical debt) with a categorical one (pre-bankruptcy out-of-pocket expense). The categories are the most precise measures we have of out-of-pocket expense estimates for the full core CBP sample. Fourth, the variables are drawn considerably from self-reported questionnaire data and thus face the same challenges as other interview and questionnaire studies. But to emphasize, this limit applies to both the questionnaire data *and* the court records. This is not a situation in which a debtor says one thing while a court or creditor says another. Fifth, this study is exclusively of bankruptcy filers by design. This means that we cannot directly compare how bankruptcy filers and non-filers deal with their

<sup>137</sup> For example, CSI Financial Services “takes over” a patient’s account and offers extended payment plans, but the hospital takes back the debts upon default on the payment plan. Richard Haugh, *Financial Aid: From Direct Debts to New Loans, Patients Get New Ways to Pay Off Hospital Bills*, HOSP. AND HEALTH NETWORKS, Nov. 2006, at 18. Neither CSI Financial Services, nor the banks doing the interim financing, would not be detected as medical on Schedule F under most coding protocols. Some bulk medical debt buyers do not have medical-sounding names. See *In re Andrews*, 394 B.R. 384 (Bankr. E.D.N.C.2008) (discussing bulk buyers in a different context).

<sup>138</sup> Diagnosis information was collected for the subset of respondents who participated in telephone interviews.

medical bills.<sup>139</sup> Sixth, we compare court records and questionnaire data for a sample that was drawn in 2007 whereas the DOJ sample was collected in the early 2000s. We cannot prove, of course, that a companion survey to the DOJ court record sample would produce similar results to ours. But, as Table 1 illustrates, we do know that our Schedule F data and the pre-BAPCPA Schedule F government data (reported in Table 1) are similarly patterned. In addition, although our literature review focuses largely on more recent publications, we do not believe that medical practice management advice was qualitatively different in the first half of the decade.<sup>140</sup>

We also should take care to note some significant demographic patterns in questionnaire-reported expense, Schedule F medical debt, and use of cash and credit for medical bills that affect the accuracy of a court-record-only study of medical burden.<sup>141</sup> For example, homeowners and non-homeowners had equal frequency of identifiable Schedule F medical debt, as well as similar distributions across the dollar ranges of Schedule F medical debt.<sup>142</sup> But on the questionnaire, homeowners were more likely to report incurring expense within the two years prior to filing (81% versus 73%) and had a different distribution of expenses than non-homeowners. Homeowners also were more likely to report using credit cards -- and, of course, home equity loans -- for medical bills than non-homeowners.<sup>143</sup> A stand-alone analysis of the court records blunted these differences.

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<sup>139</sup> We see glimpses of a difference between the bankruptcy population and the general population. For example, in the tracking survey of the *Center for Studying Health System Change*, more than half of respondents who reported problems paying medical bills said that providers suggested that they undertake payment plans. Peter J. Cunningham, Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families 2003-2007, Center for Studying Health Care Change Tracking Report No. 21, p. 3 (Sept. 2008). Even among bankruptcy filers who identified medical bills as a reason for bankruptcy, only about a third reported being in payment plans directly with their providers although it is of course possible that providers suggested plans to more of them. We will discuss provider payment plans in more depth in a separate paper.

<sup>140</sup> See discussion in Jacoby & Warren (2006).

<sup>141</sup> We found few statistically significant differences in the average amount of Schedule F medical debt among those with differing education levels, gender, race, or living arrangements. We also tested for a variety of demographic differences in medical bill management—e.g., age, race, gender, homeownership, and marital status—and again many were not significant. For example, we did not find a significant difference in bill management between respondents who indicated that they lived with a permanent partner and those who lived alone.

<sup>142</sup> The homeownership variable includes everyone who reported owning a home within five years prior to filing.

<sup>143</sup> Nearly three out of ten (27.9%) of those petitioners that owned a home in the five years prior to bankruptcy reported using a regular credit card to pay their medical bills, compared to 17 % of those who did not own a home. As previously noted, 5.8% of homeowners used a home equity loan to pay medical bills. Strangely, 1.2% of filers who said they did not own a home at any time in the prior five years selected this option on the questionnaire. It is possible that the language of the selection led them to believe that this option included lines of credit not secured by homes. Or, they used someone else's home as collateral. In any event, this difference, like the difference in credit card usage, is statistically significant to the 0.000 level.

We encountered a similar phenomenon regarding medical expenses among petitioners who identified as African American with petitioners who identified as White.<sup>144</sup> In our sample, there was not a statistically significant difference between African American petitioners and White petitioners in the frequency or average amount of Schedule F medical debt.<sup>145</sup> But on the questionnaire, African American petitioners less frequently reported out-of-pocket medical expense than most other petitioners, and African American petitioners with medical expense were much less likely to use credit cards or home equity loans (and as likely to use cash) for the bills they did incur.<sup>146</sup> African American petitioners also had significantly less credit card debt in their files generally than other respondents. Looking at the patterns across the distribution of both measures of medical burden, it appears that African American petitioners in our sample were less likely to have reduced or eliminated medical bills owed directly to providers by the time they got to bankruptcy than White petitioners. This means that Schedule F is somewhat more reflective of their pre-bankruptcy burdens than it is for other filers, although still not a perfect match. Other variables could be driving this finding for which we cannot control with our dataset, most notably differences in the ability to access medical care and credit.

A final example is the small group of youngest filers: households with at least one petitioner under 25. The youngest filers reported having Schedule F medical debt with much greater frequency than any other age group or all other age groups combined. In addition, on average, households where at least one of the filers was under the age of 25 had an average medical debt on Schedule F of \$13,263, compared to an average of \$5,846 for all other age groups.<sup>147</sup> Yet, relying on this measure alone would overstate young

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<sup>144</sup> The written questionnaire asked respondent to indicate the group with which they identify, with the options of “African American or Black, Asian American, Hispanic or Latino/a, White or Caucasian, Other (please specify), or none.” The questionnaire asked for the same information about partners of respondents. For our comparisons, we are using the majority of respondents who identified as African American and reported either no partner (57%) or identified his or her partner as African American (31%).

<sup>145</sup> 49.4% of households with African American petitioners listed medical debt on Schedule F compared to 52.6% of White filers, and households with African American petitioners listed smaller average medical debt (\$5,688) than did White filers (\$6,513), but both of these differences are outside the standard levels for statistical significance. Households with African American petitioners did, however, have a lower median Schedule F medical debt (\$1,349) than White petitioners (\$1,746) and this difference is significant to the 0.05 level. The DOJ report used averages and not medians and thus would not have illustrated this difference.

<sup>146</sup> Seventy-six percent of respondents with an African American petitioner reported using cash to pay medical bills, versus seventy-seven percent of White respondents, a difference that is not statistically significant. African American petitioners with expense were much less likely than White petitioners to report using a credit card to pay medical bills (11.3% versus 30.1%). This difference persists when we examine the use of home equity loans to pay off medical expense (1.7% versus 5.3%), and continues when we focus on only those who owned homes sometime within the five years prior to filing (2.2% versus 6.88%). The difference in credit card and home equity loan use (including either measurement) is significant to the 0.000 level.

<sup>147</sup> Although younger filers have a much higher average Schedule F medical debt than everyone else, the difference between the medians (\$1,672 for the youngest versus \$1,590 for the older filers) is not statistically significant, suggesting that the average among the youngest filers is skewed by a small number of huge Schedule F medical

filers' relative likelihood of having out-of-pocket medical expense in the two years prior to filing, and may speak instead to their lack of bill-shifting options.<sup>148</sup> Although differing attitudes about debt and other factors might play some role, these filers were less likely than other households to report using a regular credit card for medical bills and had less credit card debt in their files generally.<sup>149</sup> They were also more likely to report using a provider payment plan or doing "something else" about a medical bill, which often meant doing nothing other than dealing with the bill in bankruptcy.<sup>150</sup> Both of these latter options increase the likelihood of pre-bankruptcy medical bill showing up as Schedule F medical debt. Likewise, a much greater proportion of bankrupt households with younger women petitioners (34 and younger) retained direct obligation that appeared as Schedule F medical debt than other groups. We discovered from the questionnaires that such households were less likely to use a regular credit card or a home equity loan for medical bills and much more likely than others to report a provider payment plan or "something else."<sup>151</sup>

These demographic observations warrant further study with additional controls. But this preliminary look adds another layer of complexity to an exclusively court record study of medical debt burden.

#### IV. Discussion

Our study is the first to demonstrate through detailed systematic analysis that the DOJ's court record method, standing alone, is an unreliable measure of the financial burden of illness or injury faced by bankruptcy filers. In our nationally-representative sample of filers, the court record method produced a skewed undercount of medical bills and completely omitted filers that even the most skeptical of observers would describe as having significant medical hardship. The shifting of obligations to other creditors with non-medical identities played a large role in the discrepancy between court record and survey information, particularly for respondents with the largest verifiable gaps in measures. Absent

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debts. We saw a glimpse of that in Figure 1, where three of the six of the filers with Schedule F medical debts over \$100,000 were under the age of 25.

<sup>148</sup> On a filer-by-filer basis, the very youngest respondents were much more likely to have the same category of expense on both measures than everyone else (46% versus 36% of everyone else).

<sup>149</sup> In households in which either petitioner was under 25 years old, 18.9% reported using credit cards for medical bills, compared to 24% of all other petitions. This difference is not statistically significant. These youngest filers also had a lower frequency of home equity loan use for medical bills (2.1% versus 4.2% for all other petitioners), but this difference is outside traditional levels for statistical significance.

<sup>150</sup> Under-25 petitioners with out-of-pocket expense reported provider payment plans 27.4% of the time, compared to all other petitioners, who reported payment plans 22.8% of the time. The younger petitioners reported doing "something else" to handle expenses 21% of the time, compared to the 9.5% usage by all other petitioners. Both of these differences are statistically significant to the 0.005 level.

<sup>151</sup> Looking at the use of credit, the difference between the groups is significant to the 0.000 level, using a standard ANOVA test. The difference in use of "something else" is also statistically significant to the 0.000 level, while the differences in the use of cash are too small for there to be a statistically significant difference.

changes to the forms on which information about debts is collected, the DOJ court record methodology should not be used to measure the financial burden of health care on bankrupt families.

From the demographic assessment, we see that the court record method could be a better reflection of medical bill burden for some groups of filers than for others. Yet, court records, standing alone, are not well-suited to distinguish these filers on demographic criteria such as age and racial identity.

Furthermore, lawmakers and scholars who relied on the DOJ court record study have made no public efforts to draw such distinctions.

The clock cannot be turned back to 2005, when the DOJ analysis allowed lawmakers to vote with a clearer conscience in favor of the Bankruptcy Abuse and Consumer Protection Act of 2005 and against amendments that members of Congress proposed to protect people with medical problems from certain harsher effects of the bill.<sup>152</sup> However, our study should guide the use and interpretation of studies currently being debated in the context of health care finance reform.

We do think that the court record approach is more useful to understand the impact on *providers* of patients' bankruptcy than the impact of medical bills on patients. Consistent with the medical practice advice reviewed in Part II, health care consultants are concerned that "the last bill people pay is often their healthcare debt."<sup>153</sup> One might have thought that families headed to the bankruptcy court would overwhelmingly defer dealing with their medical bills. However, due to activities between the time of treatment and the time of bankruptcy, far fewer bankruptcy filings directly affected medical providers' receivables and those that did were for substantially smaller amounts. In our national sample, providers who treated patients with some self-pay obligation within two years before they filed for bankruptcy – while many already were struggling financially – could have ended up as claim holders in nearly eight out of ten bankruptcy cases. Even nearing bankruptcy, a third of filers with medical obligation had managed to protect their providers entirely from the bankruptcy process and many others reduced the dollar amount

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<sup>152</sup> See generally Melissa B. Jacoby, *Bankruptcy Reform and the Cost of Sickness: Exploring the Connections*, 71 MO. L. REV. 903, 908, n.21 (2006) (reviewing successful and unsuccessful medical-related amendments). We recognize that the legislation as a whole had been pending in various forms since 1997, and lawmakers across the political spectrum were evidently responsive to credit industry pressure to enact it. See generally Melissa B. Jacoby, *Negotiating Bankruptcy Legislation Through the News Media*, 41 HOUS. L. REV. 1091, 1118 (2004).

<sup>153</sup> Robert Czerwinski & Peter M. Friend, *Selling Written-Off A/R*, HEALTH CARE FIN. MGMT., Sept. 2008, at 128, 130; See also *A New World of Health Care: More Patients Seek Help with Bills*, HEALTH CARE COLLECTOR, Nov. 2008, at 1 (citing industry expert saying "As everyone knows, we are often the last bill people pay. I thought it was telling this past month when we heard people say they had to buy books, pay school fees, or pay for their kids' participation in sports so they could not pay the hospitals. Why? Other folks won't let you in without paying, but hospitals will.").

of the obligation.<sup>154</sup> Some filers who reported the largest possible out-of-pocket expense within the two years prior to filing had no medical providers as creditors in the court records. Because the proportion of cases with Schedule F medical debt includes much older debt, providers' "success" in eliminating liability from patients on the brink of bankruptcy is even greater than the comparison of measures would suggest at first blush.

## V. Conclusion

Nearly all patients, whether or not insured, have direct money dealings with their medical providers. A body of advice and technological tools help providers manage risks associated with this financial exposure, including encouraging the use of third-party credit. Our study demonstrates how these practices affect the empirical study of medical burden on patients. In our sample, an exclusively court record study would not merely produce a more conservative measure of medical burden; it would hide or diminish cases in which medical bills were particularly significant.

The health care finance debate has intensified the interest in medical bills among bankruptcy filers. Our study urges caution in using the DOJ court record analysis or other such studies to measure patient medical debt on a standalone basis. It also casts doubt on efforts to refute survey studies based on court documents alone. Absent changes to the forms on which filers report their debts, or, perhaps, substantial changes in medical bill management, court records on their own cannot tell us much about the burden of medical bills on financially distressed families. At best, they shed light on the impact of patient bankruptcy on health care providers – an important but distinct question.

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<sup>154</sup> In theory, preferential transfer law polices eve-of-bankruptcy payoffs of creditors, including medical providers. *See, e.g.*, 11 U.S.C. § 547; *Cruse v. Hannibal Health Care Sys. (In re Watkins)*, 325 B.R. 277 (Bankr. E.D. Mo. 2005) (applying preference law and ruling for trustee to recover execution on bond for payment of medical bills subject to state court judgment). Although the law is not uniform, some courts find that a creditor is vulnerable to preference attack even if the debtor simply substitutes another creditor (for example, a credit card or credit card convenience check) to pay the antecedent debt. *See, e.g.*, *In re Marshall*, 550 F.3d 1251 (10th Cir. 2008); *In re Wells*, 382 B.R. 355 (6th Cir. BAP 2008); *Flatau v. Walman Optical Co. (In re Werner)*, 365 B.R. 283 (Bankr. M.D. Ga. 2007). But for a variety of legal and practical reasons, preference law is unlikely to have an effect on medical bill payment pre-filing in most consumer bankruptcy cases. First, the preference period is relatively short (ninety days, as mentioned) unless the beneficiary is an insider. 11 U.S.C. § 547(b)(4) (setting 90-day preference period generally and one year look-back period for insiders). Second, recipients of transfers of value less than \$600 have an absolute statutory defense to preference actions in consumer bankruptcy cases, and thus case trustees would not pursue such cases. *Id.* § 547(c)(8). Third, providers will have a defense if they accepted payment in the ordinary course of business, which Congress in 2005 defined broadly to protect more payment recipients. *Id.* § 547(c)(2).

<b>Appendix A: Distribution of Difference between Schedule F Medical Debt and Out-of-Pocket Expense from Questionnaire</b>		
	Number	Percent
Four categories more on Schedule F than on the questionnaire (-4)	19	0.78
Three categories more on Schedule F than on the questionnaire (-3)	26	1.07
Two categories more on Schedule F than on the questionnaire (-2)	96	3.93
One categories more on Schedule F than on the questionnaire (-1)	224	9.18
Same category of medical debt on Schedule F and the questionnaire (0)	834	34.18
One category more on the questionnaire than on Schedule F (+1)	584	23.93
Two categories more on the questionnaire than on Schedule F (+2)	373	15.29
Three categories more on questionnaire than on Schedule F (+3)	79	3.24
Four categories more on the questionnaire than on Schedule F (+4)	36	1.48
Missing either questionnaire or Schedule F data (excluded from analysis)	169	6.93
Total	2440	100

<b>Appendix B: Medical Bill Management By Difference Between Schedule F Medical Debt and Out-of-Pocket Expense as Reported on Questionnaire</b>							
	<b>Pay with cash, check, or debit card</b>	<b>Pay with a regular credit card</b>	<b>Pay with a medical credit card</b>	<b>Agree to a payment plan with the medical provider</b>	<b>Something else</b>	<b>Pay with money from a home equity loan or other line of credit</b>	<b>Pay with money from a home equity loan or other line of credit (Home owners only)</b>
	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)
-4	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
-3	87.5% (0.342)	12.5% (0.342)	0.0% (0)	12.5% (0.342)	12.5% (0.342)	6.3% (0.25)	7.7% (0.277)
-2	90.4% (0.298)	13.5% (0.345)	1.9% (0.139)	26.9% (0.448)	7.7% (0.269)	1.9% (0.139)	2.9% (0.171)
-1	78.5% (0.412)	11.4% (0.319)	2.7% (0.162)	28.2% (0.452)	12.8% (0.335)	2.0% (0.141)	3.1% (0.175)
0	73.6% (0.441)	19.3% (0.395)	1.4% (0.119)	31.7% (0.466)	13.8% (0.345)	3.0% (0.172)	4.2% (0.200)
+1	82.5% (0.380)	25.2% (0.434)	2.6% (0.158)	19.7% (0.398)	9.1% (0.288)	4.8% (0.214)	5.8% (0.234)
+2	81.0% (0.393)	39.1% (0.489)	4.3% (0.203)	23.6% (0.425)	7.8% (0.268)	4.6% (0.209)	5.7% (0.232)
+3	76.0% (0.430)	39.2% (0.491)	3.8% (0.192)	27.8% (0.451)	12.7% (0.334)	10.1% (0.303)	13.1% (0.340)
+4	66.7% (0.478)	50.0% (0.507)	0.0% (0)	22.2% (0.422)	19.4% (0.401)	19.4% (0.401)	26.9% (0.452)
Tot al	79.0% (0.407)	26.0% (0.438)	2.6% (0.159)	25.1% (0.434)	10.8% (0.310)	4.5% (0.207)	5.9% (0.236)
Prob > F	0.0020	0.0000	0.2612	0.0013	0.0465	0.0001	0.0001

<b>Appendix C: Medical Bill Management Of Those Who Reported \$10,000 or More in Expense and no Schedule F Medical Debt</b>							
	Pay with cash, check, or debit card	Pay with a regular credit card	Pay with a medical credit card	Something else	Agree to a payment plan with the medical provider	Pay with money from a home equity loan or other line of credit	Pay with money from a home equity loan or other line of credit (Home owners only)
	Percent	Percent	Percent	Percent	Percent	Percent	Percent
All other respondents (Standard Deviation)	73% (0.45)	23% (0.42)	2% (0.15)	10% (0.30)	23% (0.42)	4% (0.19)	5% (0.225)
\$10,000 more reported on Questionnaire than on Schedule F (Standard Deviation)	67% (0.48)	50% (0.51)	0% (0.00)	19% (0.40)	22% (0.42)	19% (0.40)	27% (0.452)
Probability > F	0.4218	0.0002	0.000	0.3465	0.9054	0.0029	0.0000

<b>Appendix D: Definite Credit Card Debt Reported on Schedule F, by Difference between Schedule F Medical Debt and Out-of-Pocket Expense from Questionnaire</b>	
	Mean (standard deviation)
-4	\$15,148.75 (24950.728)
-3	\$14,518.50 (25589.335)
-2	\$9,754.48 (16860.425)
-1	\$13,457.91 (20811.045)
0	\$15,075.98 (22072.988)
+1	\$19,892.82 (26959.325)
+2	\$27,334.37 (34652.081)
+3	\$28,890.91 (32613.587)
+4	\$34,523.00 (27361.75)
<b>Total</b>	<b>\$18,837.03 (27361.75)</b>
Prob > F	0.0000

<b>Appendix E: Credit Cards To Make Ends Meet, By Difference between Schedule F Medical Debt and Out-of-Pocket Expense from Questionnaire</b>		
	<b>Put necessities on the credit card (for example, food, or monthly bills)</b>	<b>Consolidated debts with a credit card or new loan</b>
	Percent (standard deviation)	Percent (standard deviation)
-4	47.4% (0.513)	36.8% (0.496)
-3	42.3% (0.504)	15.4% (0.368)
-2	40.6% (0.494)	17.7% (0.384)
-1	40.2% (0.491)	25.0% (0.434)
0	52.3% (0.5)	31.4% (0.464)
+1	56.5% (0.496)	37.3% (0.484)
+2	65.7% (0.475)	46.1% (0.499)
+3	64.6% (0.481)	43.0% (0.498)
+4	75.0% (0.439)	47.2% (0.506)
<b>Total</b>	<b>54.5%</b> (0.498)	<b>34.7%</b> (0.476)
<b>Prob &gt; F</b>	<b>0.0000</b>	<b>0.0000</b>

<b>Appendix F: Medical Reasons for Filing for Bankruptcy, by Difference between Schedule F Medical Debt and Out-of-Pocket Medical Expense from Questionnaire</b>			
	<b>Medical or health care bills, including prescription medications</b>	<b>Medical problems experienced by you or your spouse or partner</b>	<b>Medical problems of other family members (such as children or parents)</b>
	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)
-4	21.1% (0.419)	26.3% (0.452)	5.3% (0.229)
-3	26.9% (0.452)	30.8% (0.471)	3.8% (0.196)
-2	22.9% (0.423)	29.2% (0.457)	8.3% (0.278)
-1	25.0% (0.434)	28.6% (0.453)	8.9% (0.286)
0	27.9% (0.449)	28.9% (0.454)	9.0% (0.286)
+1	25.2% (0.434)	31.0% (0.463)	10.6% (0.308)
+2	32.4% (0.469)	36.5% (0.482)	13.1% (0.338)
+3	53.2% Z(0.502)	46.8% (0.502)	24.1% (0.43)
+4	66.7% (0.478)	66.7% (0.478)	25.0% (0.439)
<b>Total</b>	<b>28.9%</b> (0.453)	<b>31.9%</b> (0.466)	<b>10.7%</b> (0.31)
<b>Prob &gt; F</b>	<b>0.0000</b>	<b>0.0000</b>	<b>0.0002</b>