
Bankruptcy Reform and the Costs of Sickness: Exploring the Intersections

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I. INTRODUCTION

Two important developments in the personal bankruptcy system unfolded over the course of the last several years: lawmakers considered and ultimately passed an omnibus bankruptcy bill,¹ and researchers began to delve more broadly and deeply into medical-related financial distress among bankruptcy filers. Drawing on prior scholarship, this article contributes to this symposium by considering what, if anything, these developments have to do with one another.

Part I briefly reviews two recent empirical studies of bankruptcy filers and the findings they produced. Although these findings may not have had discrete prescriptive implications for bankruptcy reform, they have contributed to a more subtle and complex understanding of medical-related financial distress. Part II identifies some of the medical-specific amendments in the Bankruptcy Abuse and Consumer Protection Act (BAPCPA), and explains why the findings from the empirical studies were not likely to have altered BAPCPA more substantially.

Part III considers the future intersections between BAPCPA and households with medical-related financial distress, largely from an *ex post* perspective. BAPCPA increases administrative costs substantially and this may have a bigger effect on these households than the substantive provisions of BAPCPA. BAPCPA may also signify a reduced commitment to governmental management of household risk and may be followed by future erosions in social insurance. This article concludes with a note of how BAPCPA might affect the course of future research on medical-related financial distress.

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1. Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, 119 Stat. 23 (codified as amended in scattered sections of 11 U.S.C.) [hereinafter BAPCPA]. For simplicity's sake, I will refer to the bill as BAPCPA throughout this article even though I sometimes will be referring to prior versions of the bill that technically had different names.

II. RECENT CONSUMER BANKRUPTCY PROJECT FINDINGS ON MEDICAL PROBLEMS

In 1999 and 2001, researchers associated with the Consumer Bankruptcy Project conducted surveys of personal bankruptcy filers.² Like prior Consumer Bankruptcy Project studies undertaken in 1991 and 1981, these studies included questions and analyses that captured some medical-related financial distress.³ The 1999 and 2001 studies built on the findings of the earlier studies by asking more explicit questions about insurance and medical problems.⁴ In addition, the 2001 study combined written questionnaires and court records with in-depth follow-up telephone interviews about medical problems.⁵

It is common to assume that studies of medical-related bankruptcy are principally focused on medical debt. Direct medical debt clearly is an important policy issue. For example, in a recent nationally representative study of the general population, a fifth of all respondents reported that they currently had an overdue medical bill.⁶ Almost a fifth of the sample reported that health care costs were their biggest monthly expense not counting a mortgage or rent

2. For an overview of the Consumer Bankruptcy Project, from the 1981 study through the 2001 study, see Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 545 n.73 (2006). For reports generated from the 1999 study see, for example, Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Medical Problems and Bankruptcy Filings*, 5 NORTON BANKR. L. ADVISOR 1 (2000); 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 (2001); Teresa A. Sullivan, Deborah Thorne & Elizabeth Warren, *Young, Old, and In-Between: Who Files for Bankruptcy?*, 9 NORTON BANKR. L. ADVISOR 1 (2001). For reports on the 2001 study see, for example, David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS, Feb. 2, 2005, at W5-63, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1> (last visited Nov. 6, 2006); Jacoby & Warren, *supra*; Robert M. Lawless & Elizabeth Warren, *The Myth of the Disappearing Business Bankruptcy*, 93 CAL. L. REV. 743 (2005); Katherine M. Porter & Deborah Thorne, *The Failure of Bankruptcy's Fresh Start*, 92 CORNELL L. REV. (forthcoming 2006); Elizabeth Warren, *Bankrupt Children*, 86 MINN. L. REV. 1003 (2002).

3. See TERESA A. SULLIVAN ET AL., THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT 141-71 (2000); TERESA A. SULLIVAN ET AL., AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA 166-77 (1989).

4. For copies of the written 2001 survey instrument, see Warren, *Bankrupt Children*, *supra* note 2, at 1028-32.

5. See Lawless & Warren, *supra* note 2, at 769-72 (explaining the methodology of the 2001 study).

6. See USA Today/Kaiser Family Foundation/Harvard School of Public Health, *Health Care Costs Survey*, at 11 chart 3 (Aug. 2005), <http://www.kff.org/newsmedia/upload/7371.pdf> (last visited Nov. 14, 2006). The figure is higher – 29% – for those with chronic conditions. See *id.* at 21 chart 11.

payment.⁷ Nonetheless, the researchers involved with the bankruptcy studies operated under the assumption that medical-related financial distress goes beyond outstanding debt owed directly to a medical provider.⁸ They not only endeavored to uncover medical-related debt by asking a wider range of questions to identify the presence of that debt but also took into account matters such as income lost due to medical problems.⁹

These studies produced higher estimates than prior studies of what some call, for shorthand purposes, “medical-related bankruptcy.”¹⁰ Employing a definition of medical-related bankruptcy that includes a wider range of medical debt problems and includes indirect costs of medical problems makes the policy implications more ambiguous. Nonetheless, a broader definition contributes to a better understanding of the subtle and complex attributes of medical-related financial distress.

For example, in the telephone surveys of debtors in the 2001 study, those who identified illness or injury or related conditions as a significant cause of their filings were asked about the nature of their actual medical problems.¹¹ The physicians who analyzed these data estimated that about half of the sick filers (or sick family members) had chronic medical conditions.¹² Information on diagnoses cannot tell us whether these debtors were financially devastated by illness or “deserved” bankruptcy relief.¹³ But these data help us explore how medical problems and financial problems become intertwined, including ways not likely to be well addressed by any bankruptcy system.¹⁴ People with chronic conditions are already particularly susceptible

7. *Id.* at 12 chart 4.

8. See, e.g., Jacoby, Sullivan, & Warren, *Rethinking the Debates*, *supra* note 2, at 388; Himmelstein et al., *supra* note 2, at W5-67.

9. Himmelstein et al., *supra* note 2, at W5-67 exhibit 2; Jacoby & Warren, *supra* note 2, at 550 fig. 2.

10. Options for measuring medical-related bankruptcy are presented in Jacoby & Warren, *supra* note 2, at 547-52; and in Letter from David Himmelstein et al. to Sen. Charles E. Grassley (Feb. 14, 2005), in 151 CONG. REC. S6010 (daily ed. May 26, 2005). Prior studies had measured the role of medical problems primarily through two methods: open-ended questions about reasons for filing and court records, both of which can be quite underinclusive. See Letter from Himmelstein et al. to Sen. Grassley, *supra*.

11. For an explanation of the telephone survey, see Jacoby & Warren, *supra* note 2, at 546.

12. Himmelstein et al., *supra* note 2, at W5-69.

13. See *In re James*, 345 B.R. 664 (Bankr. N.D. Iowa 2006) (dismissing as abusive Chapter 7 case of filer who had heart attack and medical debt because of how she had handled money that she could have used to pay creditors).

14. Already, we have some evidence that filers may continue to live with financial difficulty even if they receive a discharge. See Himmelstein et al., *supra* note 2, at W5-68 exhibit 4 (almost a third of medical bankruptcy filers reporting that they continued to have trouble paying their bills after bankruptcy). This finding is not broken

to high out-of-pocket costs.¹⁵ Several of these conditions, such as diabetes and heart disease, are particularly associated with higher costs.¹⁶ Yet, the financial implications of chronic medical problems may be even more deeply engrained. Those with chronic problems may be more likely to encounter repeated indirect costs associated with work loss, education loss, and the like. High-cost treatment coupled with loss of income may lead these households to ration their health needs for financial reasons, which may produce the need for more expensive health interventions down the road.¹⁷ Bankruptcy research provides no obvious answers but helps fill in pieces of the puzzle.

III. BAPCPA AND MEDICAL-RELATED FINANCIAL DISTRESS

BAPCPA contains several hundred pages of amendments to the Bankruptcy Code and related statutes.¹⁸ Lawmakers first introduced predecessor bills in the fall of 1997, and the legislation worked its way through Congress multiple times before finally being signed into law by President Bush in April 2005. Most of BAPCPA became effective on October 17, 2005. Although the bill was pending for this lengthy period, lawmakers discussed its details only at rare intervals, and even then only discussed a small portion of its contents.

During those intervals, lawmakers concerned that BAPCPA was too harsh discussed medical-related bankruptcy, albeit in a different way than the researchers, in their Congressional testimony.¹⁹ This is not surprising given

down by chapter, and thus it is possible that those already having trouble with bills are in Chapter 13 repayment plans. *See id.*

15. *See generally* Wenke Hwang et al., *Out-of-Pocket Medical Spending for Care of Chronic Conditions*, 20 HEALTH AFF. 267, 275-76 (2001), available at <http://content.healthaffairs.org/cgi/reprint/20/6/267> (using 1996 MEPS data, finding that families with chronically ill members are 2.6 times more likely to spend more than \$1,000 out of pocket, and higher pocket expenditures likely to continue over multiple years).

16. *See* Linda Blumberg et al., *Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs*, Urban Institute Health Policy Briefs No. 17, at 2 tbl.1 (Dec. 2005) (analysis of MEPS data).

17. *See, e.g.,* Michele Heisler et al., *Clinician Identification of Chronically Ill Patients Who Have Problems Paying for Prescription Medications*, 116 AM. J. MED. 753, 755 (2004) (studying prescription drug underuse and skimping on food and other necessities among sample of individuals aged 50 or older with most common ailments being hypertension, diabetes, and heart problems). For a longitudinal study finding adverse health outcomes among those who restrict intake of prescription drugs because of cost, see Michele Heisler et al., *The Health Effects of Restricting Prescription Medication Because of Cost*, 42 MED. CARE 626 (2004).

18. *See* Melissa B. Jacoby, *Negotiating Bankruptcy Legislation Through the News Media*, 41 HOUS. L. REV. 1091, 1099 (2004).

19. *See, e.g.,* 145 CONG. REC. S14246 (daily ed. Nov. 8, 1999) (statement of Sen. Kennedy) (“Isn’t it interesting that health care-related problems driving individuals into bankruptcy are the No. 1 reason besides job related reasons.”); 151 CONG. REC.

that the news media reported on the Consumer Bankruptcy Project studies.²⁰ Lawmakers proposed a variety of amendments to BAPCPA relating to medi-

S2465 (daily ed. Mar. 10, 2005) (statement of Sen. Dorgan) (“A very recent Harvard Medical School study found that about half of all people that have been driven to bankruptcy have suffered a major medical problem.”); *id.* at S2466 (statement of Sen. Mikulski) (“Half of all families filing for bankruptcy have faced illness or high medical costs. Medical costs, especially for seniors, are one of the fastest growing causes of bankruptcy.”); *id.* at S2467 (statement of Sen. Reed) (“according to a new Harvard Law School study, illness or high medical costs cause half of personal bankruptcies”); *id.* (statement of Sen. Lautenberg) (“I mentioned catastrophic illness because half of all bankruptcies today are the result of medical debts. Most families who are driven into bankruptcy by a medical problem probably think it can never happen to them because they have health insurance. But it can happen to anyone, and it does.”); *id.* at S2468 (statement of Sen. Levin) (“Nearly half of all of those studied in a recent research effort by Harvard Law School said that illness or medical bills drove them to bankruptcy”); *id.* at S2471 (statement of Sen. Kerry) (“One million men and women each year turn to bankruptcy protection in the aftermath of a serious medical problem – and three quarters of them have health insurance.”); H.R. REP. NO. 109-31, pt. 1, at 448 (2005), *as reprinted in* 2005 U.S.C.C.A.N. 88 (statement of Rep. Delahunt) (“Remember, more than half of middle class Americans who declare bankruptcy do so because of massive hospital bills or other catastrophic health care costs that they didn’t expect or could not anticipate.”); *id.* at 457 (statement of Rep. Berman) (“The statistics clearly point out that there have been large increases in medical debt and bankruptcy cases, caused by medical debts, coupled with significant increases in real estate prices, and that has led to a new and rapidly-growing problem ignored by this bill.”); *id.* at 457-58 (statement of Rep. Conyers) (“[T]he recent study in bankruptcy revealed that one half of the people forced into bankruptcy is because of medical bills or immediate hospital costs.”).

20. For a sampling of reports on the 1999 findings see, for example, *Adding Insolvency to Injury*, N.Y. TIMES, Apr. 30, 2000, § 3, at 16; *Women’s Health Issue: Medical Costs Cited as Key Cause of Many Bankruptcies*, L.A. TIMES, May 1, 2000, at 4; Albert B. Crenshaw, *Medical Bills Causing Bankruptcy, Study Says: Women, Older People Hurt Most Financially*, NEW ORLEANS TIMES PICAYUNE, Apr. 26, 2000, at A7. The publicity of the 2001 study did not begin in earnest until 2005 when the findings were unembargoed pending publication in a peer-reviewed journal. For examples of the resulting reports, see Justin Dickerson, *Medical Bills Induce Many Bankruptcies*, L.A. TIMES, Feb. 2, 2005, at A13; Diana Keough, *Medical Bills Blamed in Half of Bankruptcies*, CLEV. PLAIN DEALER, Feb. 2, 2005, at A1; Liz Kowalczyk, *Medical Bills Cause About Half of Bankruptcies, Study Finds*, BOSTON GLOBE, Feb. 2, 2005, at C6; *Many Bankruptcies Linked to Illness*, CHI. TRIB., Feb. 2, 2005, at 1C; Christopher Snowbeck, *Study: Bankruptcies, Medical Debt Often Tied*, PITTSBURGH POST-GAZETTE, Feb. 2, 2005, at A2. *See also* E.J. Dionne, Jr., Editorial, *A Bill Bankrupt of Pity*, WASH. POST, Mar. 1, 2005, at A15 (“Warren and her colleagues surveyed Americans in bankruptcy courts and found that half said illness or medical bills drove them to bankruptcy. . . . [and] three-quarters of the medically bankrupt had health insurance. Which is to say that even those who have insurance are often not sufficiently covered to protect them from financial disaster.”). A more extensive listing of citations and a critique of the ways in which the news media cited the study can be found in Gail Heriot, *Misdiagnosis: A Comment on Illness and Injury*

cal problems, with many defeated by the Judiciary Committee or the full House or Senate.²¹ But not all amendments met this fate, and research on medical-related financial distress may have played some role.

For example, an amendment introduced and passed in 2005 exempts seriously disabled individuals from a pre-bankruptcy credit counseling eligibility requirement.²² Other amendments make explicit that household budgets may account for health-related expenses — long-term care, health insurance, disability insurance, and health savings account expenses — when determining whether cases are presumed abusive.²³ An amendment introduced late in the legislative process added a reference to a “serious medical condition” in a provision that allows debtors to attest to “special circumstances” to overcome a presumption of abuse.²⁴

To be sure, many of these amendments may be more expressive than substantive, as they largely are consistent with pre-BAPCPA law.²⁵ To the

as Contributors to Bankruptcy and the Media Publicity Surrounding it, 10 TEX. REV. L. & POL. 229 (2005).

21. See *infra* notes 22-24. For a sampling of failed amendments, see, for example, H.R. REP. NO. 109-31, pt. 1, at 474-477 (2005), *as reprinted in* 2005 U.S.C.C.A.N. 88 (reporting on amendment expanding homestead exemption for medically distressed debtors, amendment expanding safe harbor for means test to apply to debtors whose indebtedness was substantially generated by illness, amendment modifying means test to allow additional expenses including health insurance premiums, medical expenses, and costs relating to care of foster children); S. 420, amend. 14, 107th Cong. (2001) (failed on March 7, 2001) (introduced by Sen. Wellstone, creating exemption for certain debtors who could demonstrate their filings were the result of medical expenses).

22. See 11 U.S.C. § 109(h)(4) (Supp. V 2005); S. 256, amend. 92, 109th Cong. (2005) (introduced by Sen. Feingold, passed by unanimous consent March 10, 2005). BAPCPA also excludes Chapter 13 disposable income “disability payments for a dependent child made in accordance with applicable nonbankruptcy law to the extent reasonably necessary to be expended for such child.” 11 U.S.C. § 1325(b)(2). *Compare In re Stockwell*, No. 06-10002, 2006 Bankr. LEXIS 748 (Bankr. D. Vt. Apr. 27, 2006) (denying waiver due to lack of evidence), *with In re Tulper*, No. 06-11542-SBB, 2006 Bankr. LEXIS 1093 (Bankr. D. Colo. May 22, 2006) (granting waiver).

23. 11 U.S.C. § 707(b)(2). See S. 420, amend. 38, 107th Cong. (2001) (introduced by Sen. Kennedy to allow for reasonable medical expenses and other purposes, passed by unanimous consent on March 15, 2001); S. 625, amend. 2522, 106th Cong. (1999) (introduced by Sen. Feingold to allow for expenses for long-term care, passed by voice vote on November 17, 1999); S. 256, amend. 5107, 109th Cong. (2005) (introduced by Sen. Kennedy to allow for health insurance and health savings account deductions and passed February 16, 2005).

24. See S. 256, amend. 23, 109th Cong. (2005) (introduced by Sen. Sessions to clarify the safe harbor with respect to debtors who have serious medical conditions, passed by yeay-nay vote March 1, 2005). See 11 U.S.C. § 707(b)(2)(B).

25. A search of the published pre-BAPCPA case law does not indicate a strong likelihood for successful legal challenges to the accounting of health insurance and related expenditures. See, e.g., *Handeen v. LeMaire (In re LeMaire)*, 883 F.2d 1373

extent courts disallowed certain health-related expenses pre-BAPCPA — for example, health insurance premiums for non-disabled adult children,²⁶ or deductions for supplemental insurance products²⁷ — BAPCPA does not seem to explicitly overrule these results. Nonetheless, the Bankruptcy Code now formally recognizes that some of the people who file for bankruptcy may be struggling with illness, injury, and disability and the associated costs, and even those who are presently in good health may have ongoing medical-related costs that should be taken into account.

More extensive amendment of BAPCPA to accommodate concerns about medical-related bankruptcy should not have been expected. BAPCPA supporters rarely wavered from the position that BAPCPA affected only filers who sought to abuse the system and who were readily able to repay some of

(8th Cir. 1989) (contesting rent payment to parents, subscription to professional journals, books, and conferences, but not contesting health insurance costs); *In re Hester*, 330 B.R. 809 (Bankr. M.D. Fla. 2005) (automatic deduction of retirement funds contested but automatic deduction of health insurance not contested); *In re Oimoen*, 325 B.R. 809 (Bankr. N.D. Iowa 2005) (contesting local phone service and cars for adult sons in college but not health insurance costs). When trustees have challenged health insurance expenses in litigated and published disputes, courts have generally ruled in favor of the debtors. *See, e.g., In re DeRosear*, 265 B.R. 196 (Bankr. S.D. Iowa 2001) (allowing unqualified increase in general health insurance while requiring evidence for other expense increases); *In re DeGross*, 272 B.R. 309, 315 (Bankr. M.D. Fla. 2001) (permitting deduction for high cost supplemental health insurance due to debtor's concern about lapses in coverage due to heart condition). Similarly, trustees were unlikely to have successfully challenged plan treatment of disability payments. *See, e.g., Courtney v. Traut (In re Traut)*, 282 B.R. 863 (Bankr. N.D. Ohio 2002); *In re Eddy*, 288 B.R. 500 (Bankr. E.D. Tenn. 2002); *In re Nissly*, 266 B.R. 717 (Bankr. N.D. Iowa 2001) (disability payments); *In re Presley*, 201 B.R. 570, 575 (Bankr. N.D. Fla. 1996) (overruling trustee's objection to disability insurance payment). Of course, deducting without substantiation or double-counting deductions was more likely to be questioned. *See, e.g., Smith v. Educ. Credit Mgmt. Corp. (In re Smith)*, 328 B.R. 605, 613 (B.A.P. 1st Cir. 2005) (refusing deduction of anticipated future health insurance expenses without evidence of the cost of those expenses); *In re Manske*, 315 B.R. 838 (Bankr. E.D. Wis. 2004) (cannot both have health insurance deducted from paycheck and also list as monthly expense).

26. *See, e.g., In re Galloway*, No. 04-6524, 2005 Bankr. LEXIS 878, at *5-6 (Bankr. M.D. Fla. May 16, 2005) (disallowing deduction for expenses for twenty-one year old son's dental, health, and vision insurance); *Williams v. Educ. Credit Mgmt. Corp. (In re Williams)*, 301 B.R. 62, 73 (Bankr. N.D. Cal. 2003) (disallowing deduction for expenses for twenty-seven year old son's health insurance). *See also Gill v. Nelnet Loan Servs., Inc. (In re Gill)*, 326 B.R. 611, 634 (Bankr. E.D. Va. 2005) (in case requesting discharge of student loans for undue hardship, denying accounting for adult child's health insurance as part of budget calculations).

27. *See In re DeRosear*, 265 B.R. 196, 212-13 (Bankr. S.D. Iowa 2001) (denying deduction for special supplemental health insurance that would have covered expenses related to hotels, transportation, and meals associated with cancer, heart or disability treatment).

their debts.²⁸ Thus, supporters would say that the bill did not need to be amended in any significant fashion to account for people in medical-related financial distress.²⁹ Without rejecting the existence of medical-related financial distress, they claimed that these issues were a matter of health care reform and not bankruptcy reform.³⁰

Logistical issues also prevented more extensive amendments. The findings from the 2001 study of bankruptcy filers were far more detailed than the findings from the 1999 study, and thus more helpful for policy debates, but also were embargoed pending publication in a peer-reviewed medical journal until 2005. By the time they were released, BAPCPA had been pending for nearly eight years.³¹ Deals had been struck, and BAPCPA had a solid base of support, with only discrete hot-button issues such as abortion and states' rights occasionally blocking passage.³² By 2005, major changes would have been unthinkable and outright rejection of this large piece of legislation only slightly less so.

28. For more recent examples, see 146 CONG. REC. S5383 (daily ed. June 20, 2000) (statement of Sen. Biden); 151 CONG. REC. S2459 (daily ed. Mar. 10, 2005) (statement of Sen. Hatch). This was a common approach that preceded both studies. See, e.g., 144 CONG. REC. H10224 (Oct. 9, 1998) (statement of Rep. Linder) ("We know that an unexpected medical emergency can undermine the best laid plans. Under this bill, effective and compassionate bankruptcy relief will continue to be available for Americans who need it."); *id.* at H10228 (statement of Rep. Gekas) ("There is not one poor person or unemployed person in this country, who by reason of their plight are overburdened with their financial situation, who cannot seek and cannot gain a fresh start. We guarantee a fresh start to the poor person, to the person overwhelmed with debt. We are not even talking about them in the reforms and fine-tuning that we did."). This concept was echoed in President Bush's signing statement. Press Release, White House Press Office, *President Signs Bankruptcy Abuse Prevention, Consumer Protection Act* (Apr. 20, 2005), available at <http://www.whitehouse.gov/news/releases/2005/04/20050420-5.htm>.

29. See, e.g., *Senate Rejects Medical Debt as Exemption in Bankruptcy*, HOUS. CHRON., Mar. 8, 2001, at 4 (noting that sponsors and supporters of legislation did not dispute findings, but that findings did not diminish need to restrict system with respect to debtors who could afford to pay their debts).

30. See, e.g., 146 CONG. REC. S5383 (daily ed. June 20, 2000) (statement of Sen. Joseph Biden) ("His sad story is an argument for catastrophic health insurance, not against bankruptcy reform."). This is only one of several instances of lawmakers thinking about medical-related financial distress in a very narrow fashion. For example, upon hearing of the 2001 findings, Senator Grassley commissioned a study of medical debt in the court records to be undertaken by the Executive Office for United States Trustees (EOUST). See 151 CONG. REC. S2053 (daily ed. Mar. 4, 2005) (statement of Sen. Grassley). Due to the limited source of data, the EOUST study could find only a subset of medical debt and could not study the indirect costs of illness or injury at all. *Id.* As a reply by the researchers indicated, this approach distorted the issue. Himmelstein et al., *supra* note 10.

31. For a history, see Jacoby, *supra* note 18.

32. See *id.*

IV. BAPCPA IN ACTION?

Whatever happened in the past, BAPCPA is now the law and will shape the system that filers with medical problems will encounter. This section considers the impact of the substantially revised Bankruptcy Code on filers with medical problems, largely from an *ex post* perspective.³³

A. Substantive Impact

It is possible that BAPCPA's biggest substantive impact on people with medical problems comes from provisions altering the treatment of patients by bankrupt hospitals and other health care businesses as opposed to the personal bankruptcy provisions.³⁴ The health care provisions appear directed to protecting patient interests — both bodily interests and record-related privacy interests — through the appointment of a patient ombudsman and specific restrictions.³⁵ Furthermore, in an attempt to alter the outcome in a particular case, BAPCPA also restricts the ability of a bankruptcy court to approve the sale of property of a not-for-profit entity, which may also affect present and future patients of such institutions.³⁶

In terms of personal bankruptcy, BAPCPA makes dozens of substantive legal changes, which have been reviewed extensively elsewhere.³⁷ With some narrow exceptions, these amendments apply to all filers, regardless of income level or origin of financial difficulty. On paper, these changes make bankruptcy less financially generous to debtors.³⁸ Some attorneys in the bank-

33. If it were the case that a lot of medical debt owed directly to providers was being discharged in the bankruptcy system, one might have expected supporters of BAPCPA to argue that legislation deterring bankruptcy filings would reduce the cost of health care. To my knowledge, proponents of BAPCPA did not make this argument even as they made parallel arguments that a high bankruptcy rate unduly increases the cost of credit. In any event, medical-related bankruptcy filers do not always have significant liabilities owed directly to the medical providers at the time of the filing.

34. See 11 U.S.C. § 101(27A) (Supp. V 2005). For a partial list of hospital bankruptcies, see Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 474 n.109 (2004). The BAPCPA health care provisions are discussed in detail in Harold L. Kaplan et al., *The New Bankruptcy Law and Health Care: Impact on Health Care Businesses and Potential Impact on Patient Collections*, 18 HEALTH LAW. 1 (2005).

35. See, e.g., 11 U.S.C. § 333 (appointment of ombudsman); *id.* § 351 (dictating method of patient record disposal).

36. See 11 U.S.C. § 363(d), *responding to*, *In re Allegheny Health, Educ. & Research Found.*, 181 Fed. App'x. 289 (3rd Cir. 2006).

37. See, e.g., 79 AM. BANKR. L. J. (2005) (symposium).

38. See Melissa B. Jacoby, *Ripple or Revolution? The Indeterminacy of Statutory Bankruptcy Reform*, 79 AM. BANKR. L.J. 169, 173-76 (2005). Less financial generosity itself may have health implications, as some judges now recognize. See, e.g., *Reynolds v. Pa. Higher Educ. Assistance Agency (In re Reynolds)*, 425 F.3d

ruptcy and health fields have suggested, with qualifications, that these provisions may increase the ability of health care providers to collect money from their bankrupt patients.³⁹

To some extent, however, such statutory changes are filtered through the repeat player professionals who operate the legal system (in the bankruptcy context, judges, trustees, and lawyers).⁴⁰ Although BAPCPA constrains judicial discretion on certain questions, such as what constitutes abuse of the system under section 707(b), BAPCPA enlarges judicial discretion in many important respects.⁴¹ BAPCPA's inartful drafting also presents issues of statutory interpretation that give judges and litigants considerable power to shape the amendments' consequences.⁴² All of this suggests that the substantive Bankruptcy Code changes from BAPCPA will be less uniformly consequential for filers with medical problems. For example, assuming we could even measure it, I would be reluctant to predict that the amendments to the discharge-related provisions will cause bankruptcy filers with medical problems to discharge less medical debt on a per-case basis than they did pre-BAPCPA.

Even if the shift in substantive law were demonstrably more severe, we lack a good baseline from which to measure BAPCPA's effect. Empirical studies of bankruptcy filers have focused much more intensively on the front end of the bankruptcy process and generally can tell us neither how bankruptcy contributes to (or detracts from) financial recovery nor how this recovery might have unfolded without bankruptcy.⁴³ Many medical-related bank-

526, 530-31, 533 (8th Cir. 2005) (en banc) (majority of panel upholding bankruptcy judge's consideration of non-pecuniary impact of major student loan indebtedness when determining whether debt is undue hardship).

39. See Kaplan et al., *supra* note 34, at 9-10 ("Even though health care providers may experience improved patient collections after the October 17, 2005 effective date of the Act due to the changes affecting consumer bankruptcies which are generally thought to make it more difficult for individuals to have their unsecured, nonpriority debts discharged, some health care providers may face some pressure to compromise their claims with individuals prior to bankruptcy or risk having their claims reduced by up to 20% in a bankruptcy case.").

40. See Jacoby, *supra* note 38, at 177-182.

41. Examples include whether repeat filers should receive extensions of the automatic stay and whether filers have shown exigent circumstances warranting a waiver of the pre-bankruptcy credit counseling briefing requirement.

42. A prominent example is 11 U.S.C. § 362(c)(3)-(4) (Supp. V 2005), governing the duration of the automatic stay for certain repeat filings. For a partial list of cases puzzling over this provision, see Melissa B. Jacoby, *Bankruptcy Reform and Homeownership Risk*, 2007 U. ILL. L. REV. (forthcoming 2007).

43. For a variety of reasons, the overwhelming majority of personal bankruptcy research has studied the front end of bankruptcy. See Jacoby, *supra* note 38, at 182-190. In general, longitudinal studies tend to be far more costly than cross-sectional studies. Legitimacy, moral hazard, and "can they pay" questions have distracted and distorted research agenda and encouraged researchers to concentrate on the debtors' financial situation at the time of bankruptcy. Even theoretical work on the compara-

ruptcy cases involve people with chronic problems who will be facing additional consequences for years to come.⁴⁴ Although the bankruptcy process may help some households adjust to long-term change, its one-shot nature is not necessarily the ideal approach.⁴⁵ Thus, even if BAPCPA has reduced the generosity of bankruptcy to debtors with medical problems, it is difficult to assess the reform's larger policy impact.

B. Administrative Cost

BAPCPA has raised the cost of bankruptcy access substantially for filers, and this may present difficult choices for potential filers with medical problems. The cost increase has several components. BAPCPA and several follow-up bills have increased the court system filing fees quite substantially, and Congress continues to propose fee increases.⁴⁶ BAPCPA added a provision allowing judges to waive these filing fees for lower income debtors who are unable to pay the filing fee in a lump sum or in installments.⁴⁷ Yet, by design, receiving the fee waiver is not guaranteed even if one's income is below the statutory limit.⁴⁸ Due to revenue implications, the court system is unlikely to encourage widespread granting of waivers. Thus, one can anticipate that most people will be expected to pay the filing fee, whatever new heights it reaches, to get access to bankruptcy.

tive benefits of bankruptcy and other approaches to medical-related financial distress is in a relatively nascent stage. See Adam Feibelman, *Defining the Social Insurance Function of Consumer Bankruptcy*, 13 AM. BANKR. INST. L. REV. 129 (2005).

44. The physicians who analyzed the 2001 Consumer Bankruptcy Project telephone survey data estimated that about half of the sick filers (or sick family members) had chronic medical conditions. Himmelstein et al., *supra* note 2, at W5-69.

45. See Jacoby, *supra* note 34, at 463.

46. For a recent proposal to raise Chapter 7 filing fees for the fourth time in a year, which would result in a near doubling of filing fees from what they were a year ago, see H.R. 5585, 109th Cong. (2006).

47. See 28 U.S.C. § 1930(f) (Supp. V 2005).

48. For some cases in which the fee waiver request was rejected, see *In re Ortiz*, No. 6:06-bk-00562-KSJ, 2006 WL 1594152 (Bankr. M.D. Fla. May 6, 2006); *In re Lineberry*, 344 B.R. 487 (Bankr. W.D. Va. 2006); *In re Hairston*, No. 06-00006, 2006 WL 221344 (Bankr. D. Dist. Col. Jan. 24, 2006). For cases in which the waiver was granted, see *In re Raymond*, No. 06-10275-JMD, 2006 WL 1047033 (Bankr. D.N.H. Apr. 12, 2006) (reporting that court granted fee waiver in prior court proceeding); *In re Hooper*, No. 06-00029, 2006 WL 1234928 (Bankr. D. Dist. Col. Feb. 23, 2006); *In re Nuttall*, 334 B.R. 921 (Bankr. W.D. Mo. 2005). Courts generally are following guidelines issued by the Judicial Conference of the United States. See United States Bankruptcy Courts, Judicial Conference of the United States Interim Procedures Regarding the Chapter 7 Fee Waiver Provisions of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (Aug. 11, 2005), <http://www.uscourts.gov/bankruptcycourts/jcusguidelines.html> (last visited Nov. 6, 2006).

BAPCPA separately increased costs to filers by implementing new fee-based conditions of eligibility and discharge: a credit counseling briefing,⁴⁹ and completion of a financial management course.⁵⁰ As a practical matter, these services add at least another \$100 to the cost of a bankruptcy filing for the debtor.⁵¹

A third component of the cost increase arises from professional fees. Debtors' lawyers apparently have raised their own fees substantially in response to BAPCPA. This is not a surprise. BAPCPA gives lawyers much more work to do and holds them financially responsible for mistakes in debtors' paperwork.⁵² Chapter 13 trustee fees for administering repayment plans could increase as well.⁵³

Researchers will need more time to discern with care exactly how these increased costs are affecting the system and the filers themselves. For some households, these extra costs may alter the cost-benefit analysis sufficiently to keep them out of bankruptcy altogether, and this may have been the ultimate point of the legislation.⁵⁴ But others may ultimately forge ahead with bankruptcy if they have many thousands of dollars of debt or want to use bankruptcy to stop a state law foreclosure process on their homes.⁵⁵ For these households, the provisions of BAPCPA that increase administrative costs redistribute resources away from household expenses and away from creditors.

Bankruptcy filers also may seek to minimize the impact of the cost hike in ways that put the bankruptcy discharge at risk. For example, they might file *pro se* to avoid steep lawyers' fees, but *pro se* cases probably are more likely to get dismissed on technicalities. Or, they might file Chapter 13 rather than Chapter 7 so that they can spread attorneys' fees over time rather than

49. See 11 U.S.C. § 109(h) (Supp. V 2005).

50. See, e.g., *id.* § 727(a)(11). For further discussion, see Jacoby, *supra* note 38, at 172-73.

51. Filers are not supposed to be denied service based on inability to pay the fee, see 11 U.S.C. § 111, but for a variety of reasons, it is unrealistic to expect that many debtors will receive services without payment.

52. See, e.g., *id.* § 707(b)(4). For a discussion of the risks associated with debtor representation after BAPCPA, see Nathaniel C. Nichols, *When Harry Met Sally: Credit Counseling Under BAPCPA*, 15 WIDENER L. SYMP. J. 641 (2006).

53. Although Chapter 13 trustee fees are capped statutorily, they might still increase within that cap or the cap could be raised. See 28 U.S.C. § 586 (2000 & Supp. V 2005). For a discussion of how these fees work, see Marianne B. Culhane & Michaela M. White, *Taking the New Means Test for a Test Drive: Means-Testing Real Chapter 7 Debtors*, 7 AM. BANKR. INST. L. REV. 27, 52-54 (1999).

54. For the argument that the legislation will not also alter borrowing behavior *ex ante*, see Susan Block-Lieb & Edward J. Janger, *The Myth of the Rational Borrower: Rationality, Behavioralism, and the Misguided "Reform" of Bankruptcy Law*, 84 TEX. L. REV. 1481 (2006).

55. This is a descriptive point. Whether they *should* forge ahead under these circumstances is another matter. See, e.g., Jacoby, *supra* note 42.

paying them in a lump sum prior to filing.⁵⁶ Most Chapter 13 filers do not complete their plans and thus only receive a discharge if they request conversion to Chapter 7 (rare) or request a “hardship discharge” (even more rare).⁵⁷ Others who opt for Chapter 7, with legal advice, may do so at the cost of foregoing other health maximizing goods and services.⁵⁸

Money is fungible, of course, and personal bankruptcy filers’ choices are poorly understood, so these comments remain in the realm of speculation. The main point is that the BAPCPA cost hike may have a more fundamental impact on filers with medical problems than the bill’s substantive changes to personal bankruptcy law.

C. Signal of Social Insurance Erosion?⁵⁹

Whatever the substantive impact of the contents of BAPCPA, the bill’s enactment and overwhelming support among lawmakers raises larger questions about governmental involvement in household risk management. Enduring features of our bankruptcy system have reflected a collective decision

56. See Jay Lawrence Westbrook, *Empirical Research in Consumer Bankruptcy*, 80 TEX. L. REV. 2123, 2143 (2002); *In re San Miguel*, 40 B.R. 481 (Bankr. D. Colo. 1984) (dismissing Chapter 13 cases for lack of good faith when they paid only bankruptcy lawyer and not creditors).

57. See, e.g., Melissa B. Jacoby, *Collecting Debts from the Ill and Injured: The Rhetorical Significance but Practical Irrelevance, or Culpability and Ability to Pay*, 51 AM. U. L. REV. 229, 242 (2001).

58. For example, filers in the 2001 Consumer Bankruptcy Project study reported skimping on various things when money ran short, including food, doctors’ appointments, and prescription drugs. See Himmelstein et al., *supra* note 2, at W5-68 exhibit 4. Yet, one need not rely on bankruptcy studies for this proposition; many studies of the general population and of people with certain diagnoses have similar findings. See, e.g., Arlene S. Bierman & Chaim M. Bell, *Penny-Wise, Pound Foolish: The Costs of Cost-Related Medication Restriction*, 42 MED. CARE 623, 625 (2004) (citing examples of studies); Michele Heisler et al., *supra* note 17; Sara R. Collins et al., *Gaps in Health Insurance: An All-American Problem*, Commonwealth Fund Biennial Survey (Apr. 2006), http://www.cmwf.org/publications/publications_show.htm?doc_id=367876 (last visited Nov. 6, 2006) (reporting on differences in self-rationing of health care between insured and uninsured for financial reasons); Sara R. Collins et al., *Will You Still Need Me? The Health and Financial Security of Older Americans*, Commonwealth Fund Survey of Older Adults (June 2005), http://www.cmwf.org/publications/publications_show.htm?doc_id=282096 (last visited Nov. 6, 2006) (from a survey of individuals aged 50-70, finding that 24% reported failing to get health services or prescriptions because of cost); *Health Care Costs Survey*, *supra* note 6, at 16 chart 7, 20 chart 10 (almost 30% reporting that they failed to fill a prescription, go to a doctor when needed, cut pills or skipped doses because of cost, and 38% of those with chronic conditions reporting the same).

59. This section is derived from Melissa B. Jacoby, *Identifying and Managing Household Risk: Lessons from Bankruptcy* (2005), available at <http://privatizationofrisk.ssrc.org/Jacoby/>.

about risk allocation for nonpayment of financial obligations. The bankruptcy system has functioned as a non-waivable *force majeure* clause. From research on bankruptcy filers, we know that at least some of the liabilities on which the bankruptcy system intervenes stem from unanticipated medical problems.

The large cadre of support for BAPCPA and the central message behind it suggest that the basic tenets of the bankruptcy system will erode further in future legislative measures. Over the course of eight years, lawmakers repeatedly endorsed the bill by lopsided margins.⁶⁰ In debates and hearings, lawmakers told the American people that they should object to paying the tax that bankruptcy imposes on households in the form of higher prices on credit, goods and services.⁶¹ Absent was any mention of what these households might have been receiving in exchange. The financial characteristics of people who most likely would feel the pain of a bankruptcy tax are probably not very different from those of the people who ultimately resort to bankruptcy — just as people who struggle to pay health insurance premiums look similar to those for whom a good insurance policy prevents financial devastation from illness. Yet, the implication in the legislative debates was that people paying the bankruptcy tax got nothing, avoiding any suggestion that bankruptcy served some insurance function for them. The debates conveyed the message that our bankruptcy system either creates too much moral hazard or that it was more in the nature of a subsidy for an undeserving group.⁶²

Theoretical and empirical research comparing bankruptcy with other social insurance approaches is at only a nascent stage, so we cannot be sure that bankruptcy is more efficient than other approaches or particularly well suited to the kinds of ongoing problems that filers face.⁶³ It is likely that there are better ways of managing household risk, including medical-related risk, than a robust federal bankruptcy system. It also is likely that some of the people who operate or study the bankruptcy system are too ambitious and optimistic about what the system reasonably can accomplish.⁶⁴ Nonetheless, we often

60. Jacoby, *supra* note 18, at 1095-1106.

61. Jacoby, *supra* note 57, at 251 n.96.

62. *See id.*

63. *See, e.g.,* Kartik Athreya, *Unemployment Insurance and Personal Bankruptcy*, 89 FED. RES. BANK OF RICH. ECON. Q. 33 (Spring 2003).

64. I refer in particular to Chapter 13 to the extent it is expected to result in significant creditor repayment, rehabilitate debtors, and to save homes in financially precarious circumstances. Very likely there are more efficient and effective ways to make debtors pay creditors out of future income or wealth that do not depend on this kind of government program. For various proposals, see Jean Braucher & Charles W. Mooney, Jr., *Means Measurement Rather Than Means Testing: Using the Tax System to Collect from Can-Pay Consumer Debtors After Bankruptcy*, 22 AM. BANKR. INST. J. 6, (2003); Charles W. Mooney, Jr., *A Normative Theory of Bankruptcy Law: Bankruptcy as (is) Civil Procedure*, 61 WASH. & LEE L. REV. 931, 1050-51 (2004); Hung-Jen Wang & Michelle J. White, *An Optimal Personal Bankruptcy Procedure and*

rely on second- and third-best solutions until we can develop better information, and sometimes long after that. For now, it is reasonable to conclude that the bankruptcy system has been limiting the adverse effects of events for which affordable and adequate insurance policies were unavailable. From this perspective, the danger presented by BAPCPA for average American households (many of whom, rationally or otherwise, now fear that medical problems will ruin them financially)⁶⁵ does not come from this bill's actual contents. Instead, it comes from the bill's signal that the U.S. bankruptcy system will decline in utility over time with no private or public replacement.⁶⁶

V. CONCLUSION

BAPCPA and research on medical-related bankruptcy had relatively independent pasts. Now that BAPCPA has become law, however, they are destined for an intertwined future. With the narrow exceptions mentioned in part II, BAPCPA affects all filers, including those with medical problems. BAPCPA's substantive provisions are unlikely to bring about radical change for households with medical problems, but the increased cost of bankruptcy that BAPCPA has imposed may have redistributive consequences that may either reduce the effectiveness of bankruptcy or reduce household investment in health maximizing goods and services.

BAPCPA's impact on households with medical problems also has implications for the researchers who study financial distress. Already, BAPCPA has prompted Consumer Bankruptcy Project researchers to plan another trip into the field to study people, with medical problems and otherwise, who have declared bankruptcy post-BAPCPA.⁶⁷ But one should not assume that only bankruptcy-oriented researchers will be curious about the legislation's effects. Health policy researchers now recognize that bankruptcy is a window

Proposed Reforms, 29 J. LEGAL STUD. 255 (2000). Similarly, Chapter 13 may not be the optimal government intervention with respect to home mortgage default. See Jacoby, *supra* note 42.

65. See Greenberg Quinlan Rosner Research, *Public Recognizes Debt Problem in U.S.* (July 19, 2006), <http://www.greenbergresearch.com/index.php?ID=1711> (last visited Nov. 6, 2006).

66. For a political scientist's analysis of this kind of phenomenon see, for example, Jacob S. Hacker, *Review Article: Dismantling the Welfare State? Political Institutions, Public Policies and the Comparative Politics of Health Reform*, 34 BRITISH J. OF POL. SCI. 1, 23, 28-32 (2004) (describing incremental reform over time adding up to shift of risk to different actors); Jacob S. Hacker, *Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States*, 98 AM. POL. SCI. REV. 243 (2004).

67. BAPCPA included data collection requirements that could facilitate research in the future, although the provisions have some significant limitations. See Jacoby, *supra* note 38, at 189-90; Katherine Porter, *BAPCPA's Bright Side*, 71 MO. L. REV. 963 (2006).

into the study of financially distressed, but not chronically impoverished, families.⁶⁸ They also now know that bankruptcy is serving more of an ad hoc insurance function regarding medical-related financial distress than they may have realized. These researchers will be studying and watching along with the rest of us.

68. For example, the Missouri Foundation for Health has funded a major study of medical problems in bankruptcy undertaken by health law and policy researchers. HEALTH MATTERS FOR MISSOURI, (Mo. Ass'n for Soc. Welfare, Jefferson City, Mo.) Apr. 2005, *available at* http://www.masw.org/healthaccess/newsletter_april_05.pdf (last visited Nov. 14, 2006).