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The Debtor-Patient: In Search of Non-Debt-Based Alternatives

Melissa B. Jacoby

The Debtor-Patient

IN SEARCH OF NON-DEBT-BASED ALTERNATIVES*

Melissa B. Jacoby†

> No one enters my house if he does not have with him the money to pay me, unless he is paying me monthly, in advance.
>
> Dr. Samuel Hahnemann, Letter to Dr. Karl Julius Aegidi, early 1800s[1]

I. INTRODUCTION

Samuel Hahnemann, founder of homeopathy, was both savvy and prescient. Today, patients and providers routinely enter debtor-creditor relationships, although the roles are reversed: whereas Dr. Hahnemann owed his patients services for which they had pre-paid, patients today more often are

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† Associate Professor of Law, Temple University School of Law, melissa.jacoby@temple.edu. Thanks to Gene Bishop, Charlene Davis, JoAnne Epps, Julia Ericksen, Joshua Freely, Joshua Kershenbaum, Joseph McClure, John Necci, Athena Rodbell, and Rebecca Schatschneider for the many forms of assistance they offered on this project. Special thanks to Jeffrey Morris and Mark Weidemaier for their close reads of prior drafts and helpful comments. I appreciate the financial support of Temple University School of Law. This Article is part of the Edward V. Sparer Public Interest Law Symposium, The New Economy and the Unraveling Social Safety Net.

[1] Robert Jütte, "Und es sammelte sich ohne Verdruß von Seiten des Kranken in des Arztes Beutel" - Samuel Hahnemann und die Honorarfrage ["*Thus it Passes from the Patient's Purse into that of the Doctor Without Causing Displeasure*" - *Samuel Hahnemann and Medical Fees*], 18 MEDIZIN, GESELLSCHAFT UND GESCHICHTE 149 (1999).

debtors as a result of seeking health care.[2] Accordingly, patients and providers assume legal rights and duties defined by a system of commercial debtor-creditor laws that generally cannot and do not account for the health-related origin of the debt or its implications for the debtor's health.

Part II of this Article explains the entanglement between health care and the debtor-creditor system. Part III argues that, particularly from the patient's perspective, debt and bankruptcy have disadvantages as methods of financing health care on either a stand-alone or supplemental basis. Finally, Part IV explores several alternatives for reducing dependency on debt and bankruptcy in the health care environment, as well as the respective limitations of each approach.

II. THE RELEVANCE OF MEDICAL-RELATED DEBT AND BANKRUPTCY TO THE GENERAL POPULATION

A significant portion of the population has filed for bankruptcy.[3] Since 1992, annual national case filings have increased by sixty-one percent.[4] The court system reported 1.5 million non-business bankruptcy petitions for calendar year 2002,[5] and a record-breaking beginning to calendar year 2003.[6] Although not every petition represents a new filer – some individuals have filed more than once – many filings represent more than one person. Taking that into account, more than 3.7 million individuals may have been in bankrupt households in calendar year 2001 alone.[7]

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[2] *See generally* Rhonda L. Rundle, *Pay-As-You-Go M.D.: The Doctor Is In, But Insurance Is Out*, WALL ST. J., Nov. 6, 2003, at A1.

[3] ELIZABETH WARREN & AMELIA WARREN TYAGI, THE TWO-INCOME TRAP: WHY MIDDLE-CLASS MOTHERS AND FATHERS ARE GOING BROKE 6 (2003).

[4] News Release, Administrative Office of the U.S. Courts, Need for Additional Bankruptcy Judges at a Critical Level (May 22, 2003), *available at* http://www.uscourts.gov/ Press_Releases/bkjud503.pdf.

[5] News Release, Administrative Office of the U.S. Courts, Record Breaking Bankruptcy Filings Reported in Calendar Year 2002 (Feb. 14, 2003) (reporting 1,539,111 non-business filings in calendar year 2002, and 1,577,651 filings overall), *available at* http://www.uscourts.gov/ Press_Releases/cy02.pdf.

[6] News Release, Administrative Office of the U.S. Courts, Bankruptcy Filings Continue to Increase: Records Broken for Total Filings and Non-Business Filings (May 15, 2003), *available at* http://www.uscourts.gov/Press_Releases/ 303bk.pdf. The beginning of CY 2003 is the second period of FY 2003, which is how the statistics are reported.

[7] Elizabeth Warren, *Bankrupt Children*, 86 MINN. L. REV. 1003, 1010 (2002); *see also* Teresa A. Sullivan, Deborah Thorne & Elizabeth Warren, *Young, Old, and In Between: Who Files For Bankruptcy?*, NORTON BANKR. L. ADVISER, Sept. 2001, at 1-2.

In addition to the growing number of filers,[8] debt is a significant part of the financial picture for many others who have not filed, particularly because debt pervades even lower-income households.[9] Economists Amanda E. Dawsey and Lawrence M. Ausubel caution that focusing exclusively on bankruptcy filers runs the risk of ignoring the "informally bankrupt" who may be just as numerous as actual bankruptcy filers, if not more so.[10] Ignoring the existence of the informally bankrupt may disregard "half or more of the households in a state of financial collapse, a mammoth underestimation given the soaring bankruptcy rate."[11] Studying bankruptcy filers, who have general demographic similarities to the overall population,[12] provides a window into a larger number of financially distressed households.

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[8] Bankruptcy can be initiated by creditors under 11 U.S.C. § 303 (2000), but nearly all bankruptcy cases are initiated by debtors themselves under 11 U.S.C. § 301, 302 (2000).

[9] Arthur B. Kennickell, Martha Starr-McCluer & Brian J. Surette, *Recent Changes in U.S. Family Finances: Results from the 1998 Survey of Consumer Finances*, 86 FED. RES. BULL. 1 (2000) (discussing percentage of income used for debt repayment among low-income households), *available at* http://www.federalreserve.gov/pubs/bulletin/2000/0100lead.pdf; Joanna Stavins, *Credit Card Borrowing, Delinquency, and Personal Bankruptcy*, NEW ENG. ECON. REV., July/Aug. 2000, at 18 (reporting disproportionate increase in credit card use and indebtedness among lower-income households); Arthur B. Kennickell, Martha Starr-McCluer & Annika E. Sunden, *Family Finances in the United States: Recent Evidence from the Survey of Consumer Finances*, 83 FED. RES. BULL. 1, 21 (1997), *available at* http://www.federalreserve.gov/pubs/bulletin/1997/0197lead.pdf (discussing increase in credit card usage among low-income households).

[10] *See, e.g.*, AMANDA E. DAWSEY & LAWRENCE M. AUSUBEL, INFORMAL BANKRUPTCY (Feb. 2002), *available at* http://www.ausubel.com/creditcard-papers/informal-bankruptcy.pdf. For a similar dynamic in business bankruptcy, see Lynn M. LoPucki, *A General Theory of the Dynamics of the State Remedies/Bankruptcy System*, 1982 WIS. L. REV. 311 (1982) (discussing businesses closing their doors without bankruptcy).

[11] *See, e.g.*, DAWSEY & AUSUBEL, *supra* note 10. *See also* Michelle J. White, *Why it Pays To File For Bankruptcy: A Critical Look at the Incentives Under U.S. Personal Bankruptcy Law and a Proposal For Change*, 65 U. CHI. L. REV. 685, 706 & n.81 (1998) (reporting that the "proportion of households that would benefit financially from bankruptcy is much higher than the proportion that actually file"); Michelle J. White, *Why Don't More Households File for Bankruptcy?*, 14 J.L. ECON. & ORGANIZATION 205 (1998) (same).

[12] *See generally* TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT (2000) [hereinafter SULLIVAN, WARREN & WESTBROOK, FRAGILE MIDDLE CLASS]; TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, AS WE FORGIVE OUR DEBTORS: BANKRUPTCY AND CONSUMER CREDIT IN AMERICA (1989) [hereinafter SULLIVAN, WARREN & WESTBROOK, AS WE FORGIVE]. Financially, the formally bankrupt population is different from the overall population. For example, the median income of bankruptcy filers' households around the time they file (most estimates under $30,000) is low relative to the general U.S. population. *Compare* CARMEN DENAVAS-WALL & ROBERT W. CLEVELAND, U.S. CENSUS BUREAU, MONEY INCOME IN THE UNITED STATES:

Likewise, the subset of medical-related bankruptcy filers illuminates health-related financial trouble more generally. Several recently published studies have found that between one third to more than half of bankruptcy filers owed debts to medical providers at the time of filing.[13] Although some bear modest medical debts, Gordon Bermant and Ed Flynn found a small but notable portion with large medical debts: Among those with medical debt (over half of their sample), about eleven percent reported five thousand dollars or more in medical debt, which is a significant amount relative to the mean and median incomes of the sample ($28,248 and $24,336, respectively).[14] Among a random sampling of clients who sought assistance with bankruptcy filings from the Legal Aid Society of Greater Cincinnati in 2000-2001, the average medical debt was five thousand dollars.[15] To accurately capture medical-related indebtedness, one should also consider medical debt paid off prior to the bankruptcy filing and debt financed with third-party credit.[16] In the 1999 Consumer Bankruptcy Project,[17]

2001, at 2-3 (2002) ($52,275 median family income and $42,228 median household income), *with* Ed Flynn, Gordon Bermant & Karen Bakewell, *A Closer Look at Elderly Chapter 7 Debtors*, AM. BANKR. INST. J., Apr. 2002, at 34 tbl.2 (median income of $24,336 in government sample of closed no-asset chapter 7 cases). In addition, bankruptcy filers tend to have higher debt-income ratios than non-filers. *See, e.g.*, Stavins, *supra* note 9, at 21 (evaluating 1998 Survey of Consumer Finances Data).

[13] Ed Flynn & Gordon Bermant, *The Class of 2000*, AM. BANKR. INST. J., Oct. 2001 (finding 56.2% of chapter 7 no-asset bankruptcy filers with medical debt on bankruptcy schedules); Hugh F. Daly III, Leslie M. Oblak, Robert W. Seifert & Kimberly Shellenberger, *Into the Red To Stay in the Pink: The Hidden Cost of Being Uninsured*, 12 HEALTH MATRIX 39, 56 (2002) (finding 47% with medical debt among Legal Aid Society of Greater Cincinnati clients who sought assistance with bankruptcy filings in 2000-2001 based on their files with the Legal Aid office); 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, 387 (2001) [hereinafter Jacoby, Sullivan & Warren, *Rethinking the Debates*] (finding 31.2% reported owing money to "health care providers, services, supplies" at time of bankruptcy in 1999 Consumer Bankruptcy Project). For a lower rate in an unpublished study, see Sugato Chakravarty & Eun-Young Rhee, *Factors Affecting an Individual's Bankruptcy Filing Decision*, tbl.1, Panel B (1999) (Purdue University, unpublished working paper, on file with author) (finding 40 families out of 284 bankrupt families filed due to "excessive health care bills," and finding that 22.5% of filers with excessive health care bills were in chapter 13).

[14] Flynn & Bermant, *supra* note 13, at 20; Ed Flynn, Gordon Bermant & Karen Bakewell, *A Closer Look at Elderly Chapter 7 Debtors*, AM. BANKR. INST. J., Apr. 2002, at 22 tbl.2. In 4.4% of the cases, medical debt comprised one half or more of the debtors' total unsecured debt. Flynn & Bermant, *supra* note 13, at 20.

[15] Daly et al., *supra* note 13, at 56.

[16] *See, e.g.*, Glenn B. Canner et al., *Recent Developments In Home Equity Lending*, 84 FED. RES. BULL. 241, 248 tbl.8 (1998) (finding increase in borrowers indicating medical expenses as use for home equity lines of credit and loans), *at* http://www.federalreserve.gov/pubs/bulletin/1998/199804lead.pdf (last visited Feb. 5,

about a third of the debtors indicated that they had a "substantial medical debt," namely a medical bill that exceeded one thousand dollars, was not covered by insurance, and was incurred within two years prior to bankruptcy.[18]

Households have medical-related debts notwithstanding some insurance coverage, although data on insurance coverage among bankruptcy filers remain sparse.[19] For example, the 1999 Consumer Bankruptcy Project defined those who have entered "medical related bankruptcy" as persons who identified illness or injury,[20] a substantial medical debt, or both,[21] as a

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2004); Daly et al., *supra* note 13, at 45. Even David Caplovitz's study of judgment debtors in the late 1960s found approximately 12% of debtors borrowed money to pay medical and hospital bills. DAVID CAPLOVITZ, CONSUMERS IN TROUBLE; A STUDY OF DEBTORS IN DEFAULT 30 (1974). Beyond third party credit, "[o]ut-of-pocket medical costs may well understate the full financial costs of an illness. There are expenditures associated with an illness of a family member – transportation, reconfiguration of home care environments, and so on – which people may not think of as medical costs and are often not reimbursed." James P. Smith, *Healthy Bodies and Thick Wallets: The Dual Relation Between Health and Economic Status*, 13 J. ECON. PERSP. 145, 156 (1999). Because of the difficulty of isolating medical debt from bankruptcy petitions, Sullivan, Warren, and Westbrook did not separately tabulate medical debt in their study of individuals who filed for bankruptcy in 1991. SULLIVAN, WARREN & WESTBROOK, FRAGILE MIDDLE CLASS, *supra* note 12, at 152.

[17] The 1999 Consumer Bankruptcy Project was conducted by a sociologist, a law professor, and a soon-to-be law professor during the first quarter of 1999 in the bankruptcy courts of eight federal judicial districts. For a complete description, see Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 13, at 389 (appendix fully describing data and methods of 1999 project).

[18] Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 13, at 389. Breaking the responses down by filing status, 44% of joint filers indicated substantial medical debt as compared to 31% of single filing women and 27% of single filing men. *Id.* at 393 fig.2; Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Medical Problems and Bankruptcy Filings*, NORTON BANKR. L. ADVISER, MAY 2000, at 1, 5 fig.3 (2000) [hereinafter Jacoby, Sullivan & Warren, *Medical Problems*].

[19] Bankruptcy researchers have not collected much information about health insurance coverage of bankruptcy filers, in part because the government does not ask for that information on the bankruptcy petition and schedules. SULLIVAN, WARREN & WESTBROOK, AS WE FORGIVE, *supra* note 12, at 171-72 ("It is startling that the courts, which ask for detailed information on income, require no information on a debtor's total compensation package . . . we cannot know with certainty which of our petitioners were not covered by insurance.").

[20] Illness or injury was identified by 25.2% of survey respondents as a reason for filing. Jacoby, Sullivan & Warren, *Rethinking the Debates*, supra note 13, at 387. The response was given most among joint filers (31%), and least among single-filing men (18%), with single-filing women in the middle (26%). *Id.* at 393 fig.2; Jacoby, Sullivan & Warren, *Medical Problems*, *supra* note 18, at 3 fig.1. Other frequent responses were job, credit card, family breakup, and money management. *Id. Cf.* SULLIVAN, WARREN & WESTBROOK, FRAGILE MIDDLE CLASS, *supra* note 12, at 153, 155, 157 (reporting that, in response to open-ended question about why they filed for bankruptcy, 19% of sample in 1991 reported medical-related filings not including birth or death of family member, and 7% specifically reported medical debt or the loss of medical insurance as a major cause of their bankruptcy). *See also* VISA, U.S.A. INC., CONSUMER BANKRUPTCY: BANKRUPTCY DEBTOR SURVEY (1996), *cited in* Jacoby,

reason for filing. Of those petitioners, eighty percent had some insurance in their household at the time of filing,[22] although filers in this category may have had a temporal gap of coverage.[23] Looking at debtors with health providers as creditors, even if they indicated insurance coverage, is an important reminder of insurance incompleteness:

Table 1: Insurance and Providers of Health Services and Supplies

Filing Status and Insurance	Health Provider is Creditor
Joint filers, both with insurance	39.9%
Single filer with insurance	25%
Joint filer, one with insurance	53.5%
No insurance	33.4%

Source: 1999 Consumer Bankruptcy Project[24]

Nearly forty percent of insured joint filers owed money to health providers, a rate that is higher than for uninsured filers. This discrepancy might be partly explained by the fact that uninsured filers may have not been seeking as much health care or may have received some uncompensated charity care. To gain a better understanding of the nature and

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Sullivan & Warren, *Rethinking the Debates*, supra note 13, at 382 (reporting that 16.% identified health and medical reasons for filing, and 14.3% identified medical problems as the "last straw").

[21] The 1999 study found about 46% of debtors in the aggregate. Jacoby, Sullivan & Warren, *Rethinking the Debates*, *supra* note 13, at 375.

[22] *Id.* at 407. Broken down by filing status, in the 1999 study, joint filers had the highest rate of insurance (84%) followed by single filing women (79%) followed by single filing men (74%). Jacoby, Sullivan & Warren, *Medical Problems*, *supra* note 18, at 5 fig.3. *See generally* Stavins, *supra* note 9, at 21, 25 (finding 70.73% insurance rate among bankruptcy filers in 1998 Survey of Consumer Finances, and also finding that those with health insurance were more likely to have filed for bankruptcy); JONATHAN D. FISHER, THE EFFECT OF TRANSFER PROGRAMS ON PERSONAL BANKRUPTCY 15 (U.S. Department of Labor, Working Paper No. 346, 2001) (reporting that "states with a higher percentage of people with health insurance have higher [bankruptcy] filing rates"); Chakravarty & Rhee, *supra* note 13, at 12 (finding that bankruptcy filing population was more likely to be without Medicare coverage than non-filing population, but filing population was significantly younger).

[23] In measuring the uninsurance rate overall, researchers continue attempts to distinguish between chronic uninsurance and periodic coverage gaps. *See generally* CONGRESSIONAL BUDGET OFFICE, HOW MANY PEOPLE LACK HEALTH INSURANCE AND FOR HOW LONG? 3-4 (May 2003) (reporting that the uninsured are not a static group, estimating that about 25% of the non-elderly population, or 22% of the entire population, was uninsured at any time during the year in 1998, and contending that Current Population Survey statistics overstate full-year uninsurance rate), *available at* ftp://ftp.cbo.gov/42xx/doc4210/05-12-Uninsured.pdf.

[24] *See supra* note 17.

duration of insurance coverage, the 2001 Consumer Bankruptcy Project will more closely probe these issues.[25]

Just like non-bankruptcy filers may be as indebted as bankruptcy filers, many individuals outside of the bankruptcy system may be facing substantial medical debt.[26] In an Open Society Institute study of Baltimore residents using community clinics and resource centers, who are a much lower income group overall than bankruptcy filers, 45.9 percent reported currently owing money for a medical expense. The average reported debt per person was $3,409,[27] comprising roughly forty-three percent of the reported average annual income in the sample ($7,864).[28] Yet, in this study, 52.6 percent of the individuals who owed money for medical care had some form of insurance, and the majority of the insured, 62.2 percent, were enrolled in Medicaid.[29]

Some debtors with medical problems confront multiple creditors and multiple financial problems, which raises the possibility that their indebtedness stems from a collage of factors rather than one catastrophic medical problem. Previous reports on the 1999 Consumer Bankruptcy Project have

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[25] Consumer Bankruptcy Project III (2001), Telephone Coding Book (on file with author) (asking bankruptcy filers about gaps in coverage, whether they were covered at the point of illness onset or injury, why coverage was suspended temporarily or permanently if these events occurred, insurance premium costs, excluded items, and disability insurance). For a more detailed description of this research, see Elizabeth Warren, *The Growing Threat to Middle Class Families*, 69 BROOK. L. REV. 401, 402 n.1 (2004) (describing the larger Consumer Bankruptcy Project, including each of the decade projects, Consumer Bankruptcy Projects I, II and III).

[26] *See, e.g.*, SULLIVAN, WARREN & WESTBROOK, FRAGILE MIDDLE CLASS, *supra* note 12, at 146 (discussing 1970s survey reporting "the number-one reason for taking out personal loans other than for durable goods was to pay medical costs"). Medical debt is also not unique to the United States. *See generally* Ke Xu, David B. Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus & Christopher J.L. Murray, *Household Catastrophic Health Expenditure: A Multicountry Analysis*, 362 LANCET 111 (2003); Jacek Skarbinski, H. Kenneth Walker, Laurence C. Baker, Archil Kobaladze, Zviad Kirtava & Thomas A. Raffin, *The Burden of Out-of-Pocket Payments for Health Care in Tbilisi, Republic of Georgia*, 287 J. AM. MED. ASS'N 1043 (2002) (finding that, in country with no risk-pooling mechanisms, 19% of households seeking medical care had to borrow or sell personal items to pay out of pocket health expenses).

[27] THOMAS P. O'TOOLE, OPEN SOCIETY INSTITUTE-BALTIMORE PROGRAM ON MEDICINE AS A PROFESSION, BALTIMORE SAFETY NET ACCESS-TO-CARE SURVEY 2002: HOW ARE PEOPLE ENDING UP IN THE SAFETY NET AND HOW SAFE ARE THEY? (July 30, 2002), *available at* http://www.soros.org/baltimore/safetynetaccess.pdf.

[28] *Id.*; *see also* DAVID CAPLOVITZ, CONSUMERS IN TROUBLE; A STUDY OF DEBTORS IN DEFAULT 67-72 (1974) (finding that 7.5% of individual defendants in collection lawsuits gave medical and hospital bills as a reason for default).

[29] O'TOOLE, *supra* note 27. Presumably, the Medicaid recipients either agreed to pay for uncovered services or they were inappropriately balance-billed.

discussed the overlap of job problems and medical problems,[30] but have not explored the overlap between medical problems and debtors' identification of credit card problems, trouble with managing money, and the possibility of home loss. The following table shows the correlation between identifying illness or injury as a reason for filing (twenty-five percent of the sample) and these other filing "reasons:"

Table 2: Percentage of Those Identifying Illness or Injury as a Reason for Filing Also Identifying Money-Related Reasons for Filing

Other Reasons	Injury or Illness	Correlation Pearson's R
Credit cards out of control	41%***	-.096***
Trouble managing money	31.7**	-.067*
May lose home	20.5**	.072**

* $p \leq .05$
** $p \leq .001$
*** $p \leq .000$

Source: 1999 Consumer Bankruptcy Project[31]

These data illustrate a not-insubstantial portion of filers who indicated illness or injury as a reason and who also identified monetary problems. As the correlation statistics suggest, however, those identifying illness or injury as a reason for filing were *less* likely to also identify credit cards and money management as reasons than those who did not identify illness or injury; among those *not* identifying illness or injury as a reason for filing, fifty-two percent identified credit cards out of control as a reason and 39.1 percent identified trouble managing money. In addition, money management, credit card, or home foreclosure problems simply might be financial fallout

[30] For cases illustrating the overlap, see, for example, United States v. Ascue (*In re* Ascue), 268 B.R. 739, 743 (Bankr. W.D. Va. 2001) (accident leading to surgery, chronic pain, disability, and ultimately reduced capacity to work); Balaski v. Educ. Credit Mgmt. Corp. (*In re* Balaski), 280 B.R. 395, 399 (Bankr. N.D. Ohio 2002) (severe physical deformity hindered employment); Carlson v. UNIPAC Student Loan (*In re* Carlson), 273 B.R. 481, 483 (Bankr. D.S.C. 2001) (spinal and brain injuries in car accident rendered debtor unable to work full time); Rivera v. N.J. Higher Educ. Student Assistant Auth. (*In re* Rivera), 284 B.R. 88, 92 (Bankr. D.N.J. 2002) (debtor instructed by doctor not to work in any field); Ivory v. United States (*In re* Ivory), 269 B.R. 890, 894-895, 910 (Bankr. N.D. Ala. 2001) (missed work due to severe asthma and systemic lupus leading to repeated termination of employment, leading court to conclude that illness prevents debtor from working on full time daily basis; prematurely born twins with chronic intestinal reflux, asthma, and heart problems who attend private school that can accommodate their medication schedules); *In re* Webb, 262 B.R. 685, 690-91 (Bankr. E.D. Tex. 2001) (child's need for special structure provided by private school).

[31] *See supra* note 17.

from the medical problem rather than a standalone problem. Furthermore, the 2001 Consumer Bankruptcy Project found that eighty-seven percent of households with children gave only three reasons for their filings: job loss, medical problems, or family breakup.[32]

The medical-related data, taken together, reveal the nature and extent of debtor-creditor relationships that grow out of medical care. In turn, these relationships carry a host of legal consequences dictated by debtor-creditor and commercial law, which, as the next Part illustrates, has particular limits and disadvantages.

III. LEGAL LIMITS ON THE ABILITY AND DESIRABILITY OF DEBT AND BANKRUPTCY TO FINANCE HEALTH CARE

A. *Legal Limits of the Current Bankruptcy System*

Individuals with medical problems and medical debts mostly file two kinds of bankruptcy: chapter 7 and chapter 13.[33] Chapter 7 refers to a process generally resulting in a swift discharge of debt after the liquidation of any non-exempt assets, although most debtors claim to have no such assets.[34] In chapter 13, discussed in subpart 2, the discharge of debt is generally deferred until the completion of a three-year, and sometimes longer, payment plan, composed largely of past-due mortgage or modified car loan payments.

The benefits of these types of bankruptcy for ill or injured filers are coupled with significant limitations that render bankruptcy a sub-optimal approach to health care finance for patients, providers, and the community. Many of the shortcomings of the bankruptcy system as health care finance are not flaws, but rather important structural limitations. Thus, changing bankruptcy law to make it more hospitable to the ill or injured would be inappropriate, were it

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[32] WARREN & TYAGI, *supra* note 3, at 81.

[33] *See* Melissa B. Jacoby, *Collecting Debts From the Ill and Injured: The Rhetorical Significance, But Practical Irrelevance, of Culpability and Ability to Pay*, 51 AM. U. L. REV. 229 (2001) [hereinafter Jacoby, *Collecting Debts*] (presenting data on chapter choice of medical-related filers and explaining differences between two chapters).

[34] *See, e.g.*, U.S. GENERAL ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN OF THE SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW OF THE HOUSE COMMITTEE ON THE JUDICIARY, BANKRUPTCY ADMINISTRATION: CASE RECEIPTS PAID TO CREDITORS AND PROFESSIONALS 33 (1994).

even possible. The subparts that follow address the noteworthy attributes of bankruptcy law, and the limits of each.

1. Temporary, and Potentially Permanent, Injunction on Debt Collection

A bankruptcy petition enjoins formal and informal collection efforts relating to existing debts.[35] Generally, this injunction lasts for the duration of the case, which may be a few months or a few years, depending on the type of case and the circumstances. After that, most debtors in chapter 7 and some in chapter 13 receive the protection of a permanent discharge injunction.[36] Compared with other nations, the United States bankruptcy law permits relatively unconditional discharge of debts, particularly in chapter 7.[37]

For an individual carrying debt due to her own medical problems or those of a sick family member, filing for bankruptcy will halt formal and informal collection actions,[38] and ultimately may relieve her of personal liability for some existing debts, including some relating to health.[39] If the health care crisis has passed, bankruptcy has the potential to bring the debtor back to the status quo. If it persists, bankruptcy may help the debtor adjust to the consequences of chronic health problems, including, perhaps, a lower income.

Perhaps most significantly to a debtor with continuing medical problems, however, the discharge injunction does not affect debts incurred prospectively.[40] To the extent that the debtor will continue to need expensive medical care uncovered

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[35] 11 U.S.C. § 362(a) (2000).

[36] 11 U.S.C. § 524 (2000).

[37] *Compare* PERSONAL INSOLVENCY TASK FORCE FINAL REPORT (CANADA), 103 (Aug. 2002) (comparing Canadian bankruptcy system to U.S. and other nations), *with* Johanna Niemi-Kiesilainen, *Consumer Bankruptcy in Comparison: Do We Cure A Market Failure or a Social Problem?*, 37 OSGOODE HALL L. J. 473, 491 (1999), *and* Rafael Efrat, *Global Trends in Personal Bankruptcy*, 76 AM. BANKR. L. J. 81 (2002). *See generally* Melissa B. Jacoby, *Generosity Versus Accessibility: Bankruptcy, Consumer Credit, and Health Care Finance in the US*, *in* CONSUMER BANKRUPTCY IN GLOBAL PERSPECTIVE 283 (Iain Ramsay, William C. Whitford & Johanna Niemi-Kiesilainen, eds., 2003).

[38] *See, e.g.*, *In re* Brigham, No. 01-10831-MWV, 2001 WL 1868123 (Bankr. D. N.H. Dec. 17, 2001) (imposing punitive damages, compensatory damages, and legal fees on Brigham and Women's Hospital for willfully violating automatic stay by continuing to send collection notices after debtor-patient filed for bankruptcy of which hospital was aware).

[39] 11 U.S.C. §§ 524, 727 (2000).

[40] 11 U.S.C. § 524(a) (2000).

by insurance, the bills may quickly mount again,[41] particularly if work capacity is reduced.[42] The Bankruptcy Code does not permit the debtor to receive discharges in rapid succession,[43] so she cannot readily relieve subsequent medical-related debts. Chronic health problems are a very real concern for bankruptcy filers.[44]

As a related matter, chapter 13 debtors generally cannot sweep post-petition debts into the chapter 13 plan without consent of the providers.[45] This makes sense as a matter of bankruptcy policy, but as a practical matter it means that a chapter 13 debtor must manage plan payments and also pay ongoing medical expenses in full, assuming their health care providers will continue to treat them.[46]

In addition, neither the discharge injunction specifically, nor bankruptcy generally, requires most third parties to extend new credit to the debtor.[47] The discharge injunction therefore does not force medical providers to treat delinquent debtors post-bankruptcy.[48] Furthermore, an ill or

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[41] *See, e.g.*, Phelps v. Cordia (*In re* Cordia), 280 B.R. 138, 147 (Bankr. N.D. Ohio 2001) (insulin dependent diabetic who had three heart attacks and had no medical insurance due to preexisting conditions continued to accrue medical bills post bankruptcy); Ivory v. United States (*In re* Ivory), 269 B.R. 890, 898-900 (Bankr. N.D. Ala. 2001) (substantial medical debt post petition due to surgery, hospitalization, and expensive prescription drugs, all of which cannot be discharged in this bankruptcy case); *In re* Aschtgen, No. 01-01348-D, 2002 Bankr. LEXIS 908 (Bankr. N.D. Iowa July 16, 2002) (medical expenses were post-petition and not affected by debtor's discharge); England v. United States (*In re* England), 264 B.R. 38, 48 (Bankr. D. Idaho 2001) (uninsured debtor's hypokalemic paralysis could strike at any time causing hospitalization, and children with some government health coverage will require medication and additional care in future).

[42] Jacoby, *Collecting Debts*, *supra* note 33, at 237.

[43] 11 U.S.C. § 727(a)(8), (9) (2000).

[44] *See supra* notes 18, 30, and 41.

[45] *See, e.g.*, *In re* Sims, 288 B.R. 264 (Bankr. M.D. Ala. 2003) (noting that debtor could not force post-petition medical creditors to file claims to be treated in chapter 13 repayment plan and then discharged).

[46] *See, e.g.*, *In re* Webb, 262 B.R. 685, 688-689 (Bankr. E.D. Tex. 2001) (noting that physician seemed willing to continue to treat debtor and child, but ongoing bills would have been substantial, with $500 per month in psychiatric treatments and $22,500 for multiple surgeries).

[47] *See generally* MICHAEL E. STATEN, THE IMPACT OF POST-BANKRUPTCY CREDIT ON THE NUMBER OF PERSONAL BANKRUPTCIES (Krannert Graduate School of Management-Purdue University, Working Paper No. 58, 1993); DAVID K. MUSTO, THE REACQUISITION OF CREDIT FOLLOWING CHAPTER 7 PERSONAL BANKRUPTCY (Wharton School, University of Pennsylvania, Working Paper, 1999).

[48] For an anecdote from a study of interviews with more than 130 health providers and patients, see, for example, *Second-Class Medicine*, CONSUMER REPS., Sept. 2000, at 42 (reporting on Community Health Center that instituted a policy that it would not permit future appointments for bankruptcy filers who owed money to the clinic).

injured debtor will not necessarily be relieved of all large debts, even if they were incurred pre-bankruptcy. For example, some individuals take on home equity loans or lines of credit to finance their health care.[49] Because that debt is secured, and particularly because it is secured by the debtor's principal residence, the debtor must pay that debt in full or she will lose her home.[50] Debtors also sometimes agree to remain liable on particular debts through reaffirmation agreements, and this could include medical-related debts.[51] Moreover, a debtor may not discharge an obligation to pay a child or ex-spouse's health expenses or insurance if it is in the nature of support for which the debtor is responsible.[52]

Importantly, to get a discharge from chapter 13, a debtor generally must finish her repayment plan.[53] Most chapter 13 filers do not complete their plans.[54] Data from the

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[49] Canner et al., *supra* note 16, at 248 tbl.8 (1998) (noting an increase in borrowers indicating medical expenses as use for home equity lines of credit and loans), *available at* http://www.federalreserve.gov/pubs/bulletin/1998/199804lead.pdf; Daly et al., *supra* note 13, at 45; Letter from Robert M. Hayes, President, Medicare Rights Center, to U.S. House Representatives (Mar. 18, 2003) (opposing bankruptcy legislation and discussing use of bankruptcy by ill or injured seniors to save their homes that they have mortgaged for medical expenses).

[50] 11 U.S.C. §§ 524, 727(b) (2000) (limiting the discharge to liability on claims, not creditors' in rem rights in collateral).

[51] 11 U.S.C. § 524(c) (2000); Marianne B. Culhane & Michaela M. White, *Debt After Discharge: An Empirical Study of Reaffirmation*, 73 AM. BANKR. L. J. 709, 752 (1999) (identifying reaffirmation of $1,433 medical bill at unstated interest rate). In addition, certain categories of debts (e.g., child support, taxes, student loans) are not dischargeable under most circumstances. 11 U.S.C. § 523(a)(1), (5), (8), (15) (2000). Other debts are not dischargeable in chapter 7 if they involved some debtor wrongdoing (e.g., if incurred fraudulently or if arising from willful and malicious injury). 11 U.S.C. § 523(a)(2), (6) (2000); Kawaauhau v. Geiger, 523 U.S. 57 (1998); Field v. Mans, 516 U.S. 59 (1995).

[52] *See, e.g.*, 11 U.S.C. § 523(a)(5), (15) (2000); Basile v. Basile (*In re* Basile), 288 B.R. 833, 840 (Bankr. W.D. Mo. 2003) (holding that debtor's obligation to provide health insurance for former spouse was in nature of support, pursuant to state court judgment, and thus nondischargeable). *Compare In re* Dixon, 245 B.R. 367, 369 (Bankr. W.D. Mo. 2000) (holding that divorce decree required non-debtor-ex-spouse to pay child's medical expenses, so debtor was not responsible), *with* Kimball v. Kimball (*In re* Kimball), 253 B.R. 920, 926 (Bankr. D. Idaho 2000) (holding that no evidence that payment of medical bills was allocated to debtor in nature of support).

[53] 11 U.S.C. § 1329 (2000). Although the statute permits courts to grant a "hardship discharge" to debtors who fail to finish their plans under limited circumstances, this option is infrequently granted. U.S. DEPARTMENT OF JUSTICE, U.S. TRUSTEE, CHAPTER 13 STANDING TRUSTEE FY2002 AUDITED ANNUAL REPORTS 29-35 (2003), *available at* http://www.usdoj.gov/ust /library/chapter13/ch13ar02-AARpt.pdf.

[54] For data on chapter 13 plan completion suggesting that the majority of chapter 13 filings do not result in completed plans, see Gordon Bermant & Ed Flynn, *Measuring Projected Performance in Chapter 13: Comparisons Across the States*, AM. BANKR. INST. J., July/Aug. 2000, at 22; MICHAEL BORK & SUSAN D. TUCK, BANKRUPTCY STATISTICAL TRENDS: CHAPTER 13: DISPOSITIONS (Admin. Office of the U.S. Courts,

1999 Consumer Bankruptcy Project revealed that nearly half of the chapter 13 sample indicated medical-related bankruptcy, and most of them also indicated job problems that decrease the likelihood of plan completion.[55] Thus, a large volume of chapter 13 filers with illness or injury may be even less likely to receive the protection of the permanent discharge injunction associated with receipt of the discharge.

Finally, pending bankruptcy reform legislation, if enacted, will weaken both the automatic stay and the discharge injunction.[56] The legislation adds a host of new exceptions to the automatic stay and new exceptions to discharge.[57] While they are not specifically directed to medical-related filers, they will complicate the system and affect all users.[58] The legislation also aims to shift more debtors into chapter 13,[59] where receiving a discharge is less likely.

In sum, both under the existing system and the system contemplated by pending legislation, bankruptcy offers potent but inherently limited debt relief to those with chronic health problems.

Working Paper No. 2, Oct. 1. 1994); Scott F. Norberg, *Consumer Bankruptcy's New Clothes: An Empirical Study of Discharge and Debt Collection in Chapter 13*, 7 AM. BANKR. INST. L. REV. 415, 440 (1999); Teresa A. Sullivan, Elizabeth Warren & Jay Lawrence Westbrook, *Consumer Debtors Ten Years Later: A Financial Comparison of Consumer Bankrupts 1981-1991*, 68 AM. BANKR. L.J. 121, 145 (1994); SULLIVAN, WARREN & WESTBROOK, AS WE FORGIVE, *supra* note 12, at 215-17. Professor Girth found a higher completion rate, but was looking only at confirmed plans. Marjorie L. Girth, *The Role of Empirical Data in Developing Bankruptcy Legislation for Individuals*, 65 IND. L.J. 17, 42 (1989).

[55] Jacoby, *Collecting Debts*, *supra* note 33, at 237.

[56] The latest version is the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003, H.R. 975, 108th Congress, introduced on Feb. 27, 2003, but the prior three congresses also have seriously considered and come close to passing omnibus bankruptcy legislation.

[57] *See, e.g.*, Bankruptcy Abuse Prevention and Consumer Protection Act of 2003, H.R. 975, 108th Cong. § 214 (2003) (exceptions to automatic stay in domestic support obligation proceedings); *id.* § 220 (expanded nondischargeability of student loans); *id.* § 310 (expanded nondischargeability of cash advances and "luxury goods"); *id.* § 311 (exceptions to automatic stay for residential landlords); *id.* § 312 (longer time between bankruptcy discharges); *id.* § 314 (expanded nondischargeability of credit card debts incurred to pay taxes, expanded nondischargeability in chapter 13). *See generally* Charles Jordan Tabb, *The Death of Consumer Bankruptcy in the United States?*, 18 BANKR. DEV. J. 1, 35 (2001) (discussing "systematic weakening" of discharge in reform bill).

[58] DAVID A. SKEEL, JR., DEBT'S DOMINION: A HISTORY OF BANKRUPTCY LAW IN AMERICA 205, 208 (2001).

[59] *See, e.g.*, H.R. 975, § 102 (basing dismissal or conversion of chapter 7 cases on ability to repay portion of debts according to formula).

2. Saving Access to Homes and Cars

Individuals sometimes seek bankruptcy protection when they have defaulted on a home or car loan and fear repossession or foreclosure. Chapter 13 permits debtors to cure a home mortgage default over the objection of the secured lender, and to modify the terms of a car loan to reduce the required payments.[60] These tools are not explicitly related to health, but they may be attractive to ill or injured filers.[61] A bankruptcy filer might have fallen behind on these obligations during a period of medical and financial crisis. Or, as mentioned previously, a bankruptcy filer might have financed medical care with a loan secured by their homes.[62] Both possibilities help explain not only why such a large proportion of chapter 13 payments go to secured creditors,[63] but also why so many ill or injured debtors use chapter 13, which otherwise might seem poorly suited to them.[64] However, because plan completion rates do not reveal the success or failure of home and car saving, it is not known whether this tactic works.[65]

Even if chapter 13 helps the ill or injured keep their homes and cars, pending bankruptcy legislation, if enacted, will alter this part of the system. Debtors will have to pay more to retain their cars, and in some cases their homes, than they do today.[66] Some will not be able to confirm plans.[67] Thus, if the

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[60] 11 U.S.C. § 1322(b)(2) (2000) (permitting modification of rights of holders of secured claims other than claim secured only by debtor's principal residence); *id.* § 1325(a)(5)(B) (declaring that court shall confirm plan if it permits secured creditor to retain lien and pays equivalent of present value of allowed secured claim). *See generally In re* Kidd, 315 F.3d 671, 675 (6th Cir. 2003) (describing so-called "cram down" of secured claim in chapter 13 by permitting confirmation of plan over undersecured creditor's objection if plan pays creditor value of collateral plus appropriate interest rate).

[61] The 2001 Consumer Bankruptcy Project will collect more detailed information on the extent to which health problems impede debtors' ability to maintain housing payments.

[62] *See supra* note 49 and accompanying text.

[63] U.S. DEPARTMENT OF JUSTICE, U.S. TRUSTEE, CHAPTER 13 STANDING TRUSTEE FY2002 AUDITED ANNUAL REPORTS (2003) (about 57 % of Chapter 13 distributions allocated to secured debt payments), *available at* http://www.usdoj.gov/ust/library/chapter13/ch13ar02-AARpt.pdf.

[64] *See* Jacoby, *Collecting Debts*, *supra* note 33. It also is possible that a debtor might use chapter 13 in an effort to seek to repay her medical provider over time through a chapter 13 plan in the hopes of maintaining access to health services.

[65] Jean Braucher, *Lawyers and Consumer Bankruptcy: One Code, Many Cultures*, 67 AM. BANKR. L.J. 501, 510 (1993).

[66] Bankruptcy Abuse Prevention and Consumer Protection Act of 2003, H.R. 975, 108th Cong. §§ 306, 309 (2003) (forestalling release of lien until the end of the plan or payment in full, restricting the ability to modify purchase money loans and other

bill becomes law, chapter 13 may not be a viable method for debtors to retain their homes and cars, particularly debtors who may have greater difficulty adhering to a multi-year payment plan due to ongoing medical problems and related job problems.

3. Relatively Unbureaucratic Accessibility

Bankruptcy's accessibility may be a "benefit" for debtor-patients relative to other social welfare programs. Social welfare programs often entail bureaucracy, multiple trips to different offices, repeated eligibility verifications, and little or no integration between various services.[68] Knowledgeable consideration of one's options in the social welfare realm is difficult without legal or counseling advice.[69] Medicaid, for example, divides eligibility into many separate categories.[70] It is a "horribly complicated law"[71] that is "almost unintelligible to the uninitiated."[72] Perhaps in part as a result of social welfare programs' complex bureaucratic and administrative barriers,

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loans within certain time periods prior to filing, expanding the definition of principal residence to prevent modification of loans secured by manufactured housing, changing treatment of secured debt upon conversion to chapter 7, and imposing new requirements for adequate protection of creditors in chapter 13). In addition, the bill requires that chapter 13 plans of certain debtors have a five year duration. *See id.* § 318.

[67] *See, e.g.*, Charles Jordan Tabb, *The Death of Consumer Bankruptcy in the United States?*, 18 BANKR. DEV. J. 1 (2001); Gary Klein, *Impact of Pending Bankruptcy Legislation on Low Income Debtors*, AM. BANKR. INST. J., Apr. 2000, at 182.

[68] *See, e.g.*, MARY JO BANE & DAVID T. ELLWOOD, WELFARE REALITIES: FROM RHETORIC TO REFORM 152 (1994).

[69] *See generally id.* at 134-35 (discussing how public assistance programs such as welfare, food stamps, Medicaid, and housing assistance seem to change continuously and to become ever more complicated, such that "eligiblity rules and benefit levels have become even more of a black box to clients and workers . . . more and more mysterious, and apparently arbitrary to workers and clients"); Wayne Moore, *Improving the Delivery of Legal Services to the Elderly: A Comprehensive Approach*, 41 EMORY L. J. 805, 811 (1992) (stating that 28% of the legal needs of the elderly were related to complexities of health coverage and citing THE SPANGENBERG GROUP, WISCONSIN ELDER LEGAL NEEDS STUDY, 2 THE FINAL REPORT OF THE ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY 6 (1991)).

[70] *See* 42 U.S.C. § 1396a(a)(10) (2000); Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-five*, 45 ST. LOUIS U. L.J. 7, 11 n.24, 17 (2001). *See also* Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 11 (2002) (describing eligibility requirements); Ann C. McGinley, *Aspirations and Reality in the Law and Politics of Health Care Reform: Examining a Symposium on (E)qual(ity) Care for the Poor*, 60 BROOK. L. REV. 7, 11-12 (1994).

[71] Rosenbaum & Rousseau, *supra* note 70, at 38-39. *See also* Perkins, *supra* note 70, at 9 (describing complexity and unintelligibility of Medicaid).

[72] Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976).

millions of eligible people are not enrolled, which researchers are working hard to understand.[73]

By contrast, chapter 7 bankruptcy has no eligibility requirement.[74] The grounds for rejecting a bankruptcy petition at the outset are practically non-existent,[75] the amount of information initially required is minimal, and the entry fee has been described as modest compared to that of other nations.[76] Chapter 13's eligibility requirements are fairly limited: a

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[73] IAN HILL & AMY WESTPHAL LUTZKY, GETTING IN, NOT GETTING IN, AND WHY: UNDERSTANDING SCHIP ENROLLMENT (Urban Institute, Occasional Paper No. 66, 2003) (observing that SCHIP application has been simplified more than Medicaid, observing inconsistencies that increase confusion, and finding high rate of rejections from SCHIP for procedural reasons); LISE MCKEAN, CENTER FOR IMPACT RESEARCH, ACCESS TO INCOME SUPPORTS FOR WORKING FAMILIES IN CHICAGO (Oct. 2002); BARENTS GROUP LLC, FINAL REPORT ON "REVIEW OF THE LITERATURE ON EVALUATIONS OF OUTREACH FOR PUBLIC HEALTH INSURANCE AND SELECTED OTHER PROGRAMS" (Mar. 31, 2002), *available at* http://www.cms.hhs.gov/schip/outreach/rpt33100.pdf; LISA DUBAY, JENNIFER HALEY & GENEVIEVE KENNEY, URBAN INSTITUTE, CHILDREN'S ELIGIBILITY FOR MEDICAID AND SCHIP: A VIEW FROM 2000 (Mar. 2002), *available at* http://www.urban.org/UploadedPDF/310435.pdf; JENNIFER P. STUBER, KATHLEEN A. MALOY, SARA ROSENBAUM & KAREN C. JONES, BEYOND STIGMA: WHAT BARRIERS ACTUALLY AFFECT THE DECISIONS OF LOW-INCOME FAMILIES TO ENROLL IN MEDICAID? (George Washington University Medical Center, Issue Brief, July 2000); DAHLIA K. REMLER, JASON E. RACHLIN & SHERRY A. GLIED, WHAT CAN THE TAKE-UP OF OTHER PROGRAMS TEACH US ABOUT HOW TO IMPROVE TAKE-UP OF HEALTH INSURANCE PROGRAMS? (National Bureau of Economic Research, Working Paper No. 8185, Mar. 2001); LEE ANN HALL, GWEN HAMPTON & DEEPAK BHARGAVA, NATIONAL HOUSING INSTITUTE, BRINGING DOWN THE BARRIERS: LOW-INCOME LEADERS ADDRESS OBSTACLES TO ENROLLMENT IN FEDERAL PROGRAMS (Nov./Dec. 2000), *available at* http://www.nhi.org/online/issues/114/organize.html; Avery S. Hart, *America's Health Care Safety Net: Intact But Endangered*, 284 J. AM. MED. ASS'N 2117 (2000) (book review); MICHAEL J. PERRY, EVAN STARK & R. BURCIAGA VALDEZ, HENRY J. KAISER FAMILY FOUNDATION, BARRIERS TO MEDI-CAL ENROLLMENT AND IDEAS FOR IMPROVING ENROLLMENT: FINDINGS FROM EIGHT FOCUS GROUPS IN CALIFORNIA WITH PARENTS OF POTENTIALLY ELIGIBLE CHILDREN (Sept. 1998), *available at* http://www.kff.org/medicaid/1436-index.cfm; MICHAEL PERRY, SUSAN KANNEL, R. BURCIAGA VALDEZ & CHRSTINA CHANG, HENRY J. KAISER FAMILY FOUNDATION, MEDICAID AND CHILDREN OVERCOMING BARRIERS TO ENROLLMENT: FINDINGS FROM A NATIONAL SURVEY (Jan. 2000), *available at* http://www.kff.org/medicaid/2174-index.cfm; GENEVIEVE M. KENNEY, JENNIFER M. HALEY & FRANK ULLMAN, URBAN INSTITUTE, MOST UNINSURED CHILDREN ARE IN FAMILIES SERVED BY GOVERNMENT PROGRAMS (Dec. 1999) (noting many eligible children are uninsured and yet participate in other government programs, such as National School Lunch program); JOEL S. WEISSMAN, PAUL DRYFOOS & KATHERINE LONDON, INCOME LEVELS OF BAD-DEBT AND FREE CARE PATIENTS IN MASSACHUSSETTS HOSPITALS: DOES UNCOMPENSATED CARE SERVE THE TRULY NEEDY?, 18 HEALTH AFF. 156-66 (1999) (estimating that many "bad debt" patients were sufficiently low income to have been enrolled in public programs).

[74] 11 U.S.C. § 109(b) (2000).

[75] *See* FED. R. BANKR. P. 5005(a)(1) ("The clerk shall not refuse to accept for filing any petition or other paper presented for the purpose of filing solely because it is not presented in proper form as required by these rules or any local rules or practices.").

[76] Rafael Efrat, *Global Trends in Personal Bankruptcy*, 76 AM. BANKR. L. J. 81, 107-108 (2002).

debtor must have "regular income" and her debt must not exceed a certain threshold.[77] In any event, the court probably would examine these factors only if challenged, and, even then, only after the debtor already has received automatic stay protection.[78]

Likewise, courts screen and punish wrongdoers in bankruptcy only after the debtor has entered the system. For example, a court can deny the debtor's discharge for wrongdoing,[79] which might also give rise to criminal sanctions,[80] and can dismiss a case for cause, such as bad faith[81] or substantial abuse.[82] Yet, the system essentially presumes good faith until shown otherwise.

While this more open approach has drawbacks, it does minimize administrative complexity and barriers to access. Bankruptcy may be attractive to households in financial trouble because of its less intrusive bureaucracy and its lack of complicated eligibility requirements. Whether the substantive aspects of bankruptcy are well-suited toward the problems of the chronically ill is, of course, another matter.

Technically, pending bankruptcy reform would change eligibility only slightly, but the overall impact on accessibility

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[77] 11 U.S.C. § 109 (2000).

[78] COLLIER ON BANKRUPTCY ¶ 109.01 (Lawrence P. King, ed., 15th ed. 1996 rev. 2003).

[79] 11 U.S.C. § 727 (2000); San Jose v. McWilliams, 284 F.3d 785 (7th Cir. 2002) (finding requisite elements to prove debtor transferred or concealed property with intent to hinder, delay, or defraud); Sholdra v. Chilmark Financial (*In re* Sholdra), 249 F.3d 380 (5th Cir. 2001) (affirming denial of discharge for knowingly making false oath). *See generally* Taylor v. Freeland & Kronz, 503 U.S. 638, 644 (1992) (citing denial of discharge among list of penalties for submitting fraudulent claims).

[80] 18 U.S.C. §§ 151-157 (2000); U.S. v. Brennan, 326 F.3d 176, 181 (3d Cir. 2003) (affirming bankruptcy fraud conviction for concealing gaming chips, bearer bonds, and cash from bankruptcy court); U.S. v. Sabbeth, 277 F.3d 94 (2d Cir. 2001) (denying motion for reconsideration of sentencing for bankruptcy fraud and money laundering). *See generally Taylor*, 503 U.S. at 644 (identifying title 18 criminal sanctions as remedy for debtor or debtor attorney wrongdoing).

[81] 11 U.S.C. § 707(a) (2000). *Compare* Tamecki v. Frank (*In re* Tamecki), 229 F.3d 205 (3d Cir. 2000) (finding bad faith as ground for dismissal for cause), *with* Neary v. Padilla (*In re* Padilla), 222 F.3d 1184 (9th Cir. 2000) (holding that bad faith filing is not a ground for dismissal under section 707(a)).

[82] 11 U.S.C. § 707(a), (b) (2000); Taylor v. United States (*In re* Taylor), 212 F.3d 395 (8th Cir. 2000) (upholding dismissal for substantial abuse); Kornfield v. United States (*In re* Kornfield), 164 F.3d 778 (2d Cir. 1999) (upholding dismissal for substantial abuse of high income gastroenterologist). United States trustees are now screening quite carefully for substantial abuse. *See* Hearing Before the Subcomm. on Commercial and Administrative Law of the House Comm. on the Judiciary, 108th Cong. 20 (Apr. 8, 2003) (statement of Lawrence Friedman, Director, Executive Office for United States Trustees, Department of Justice).

would be considerable.[83] Indeed, some proponents of pending reforms have cited other government programs as the model for bankruptcy reform.[84] The legislation conditions bankruptcy eligibility on seeking and receiving pre-bankruptcy consumer counseling from non-governmental counseling services, which may entail a fee.[85] Other new provisions that may serve as de facto barriers to access include: 1) analyzing all chapter 7 filings through an ability-to-pay standard that is adapted awkwardly from Internal Revenue Service guidelines and does not take into account the legitimacy of the debtor's "need" for bankruptcy relief;[86] 2) new restrictions and, potentially, financial sanctions, on lawyers who represent consumer debtors;[87] 3) new restrictions on repeat bankruptcy filings;[88] and 4) automatically dismissing cases in which debtors miss certain administrative deadlines.[89]

Although the principle behind each of these changes has merit, in the aggregate and as drafted they will make bankruptcy look more like the government programs that experience low take-up rates. Bankruptcy may become less accessible to individuals with health problems and may provide less relief for those who do gain access to the system. This reduced accessibility and generosity may correspondingly increase the risk of financing health care with debt.

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[83] *See generally* SKEEL, *supra* note 58, at 208 (describing how legislation increases costs of, and consequently discourages consumers from, filing for bankruptcy); Henry J. Sommer, *Causes of the Consumer Bankruptcy Explosion: Debtor Abuse or Easy Credit?*, 27 HOFSTRA L. REV. 33 (1998).

[84] Edith H. Jones & Todd J. Zywicki, *It's Time for Means Testing*, 1999 BYU L. REV. 177, 182 (1999); Edith H. Jones & James I. Shepard, *Recommendations for Reform of Consumer Bankruptcy Law by Four Dissenting Commissioners*, *in* NATIONAL BANKRUPTCY REVIEW COMMISSION, BANKRUPTCY: THE NEXT TWENTY YEARS 1043 (1997); Edith H. Jones & James I. Shepard, *Additional Dissent to Recommendations for Reform of Consumer Bankruptcy Law*, *in* NATIONAL BANKRUPTCY REVIEW COMMISSION, *supra*, at 1123.

[85] Bankruptcy Abuse Prevention and Consumer Protection Act of 2003, H.R. 975, 108th Cong. § 106 (2003).

[86] *Id.* § 102 (2003). For an analysis of this and related provisions, see Jacoby, *Collecting Debts*, *supra* note 33, at 253-57; Melissa B. Jacoby, *Generosity Versus Accessibility: Bankruptcy, Consumer Credit, and Health Care Finance in the US*, *in* CONSUMER BANKRUPTCY IN GLOBAL PERSPECTIVE 283, 295-97 (Iain Ramsay, William C. Whitford & Johanna Niemi-Kiesilainen eds., 2003); Sommer, *supra* note 83, at 50 (explaining that bill does not look at individualistic determinations).

[87] H.R. 975, § 102.

[88] *Id.* § 302.

[89] *Id.* § 316.

B. *Adverse Effects of Debt-Based Health Care Finance and Medical-Related Bankruptcy*

Bankruptcy is part of a broader debtor-creditor system. The debtor-creditor system includes the multiple state and federal laws that function together to govern relationships between those who owe money and those who seek to collect it.[90] This system includes elements from an array of first-year law school courses – an amalgamation of property, contract, tort, and civil procedure principles, with some constitutional limitations and occasionally a criminal component – with an overlay of bankruptcy, secured transactions, and consumer protection law. Although debt can arise in a variety of ways, this discussion focuses principally on contractually-created debts. A multifaceted compilation of statutory and common law imposes some administrative and disclosure responsibilities on the contracting parties and restricts the enforceability of the bargain under some circumstances,[91] but generally permits debtors and creditors to strike their own deals and permits creditors to enforce them through informal and formal means.

A debt may be legally enforceable even though the obligor does not understand how much she owes and the cost of the credit. Thus, although some patients with private insurance may assume they bear no personal liability for the cost of their care, they are often incorrect as a legal and practical matter. They also may have had insurance plans that can best be described as "shallow," or may have hit more generous coverage caps or exclusions;[92] either way they are liable for the cost of their care. Whether they owe the money to the provider or to some third-party lender, patients are debtors just the same, to the extent that credit enabled them to obtain services or goods without paying in cash up front. Even

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[90] *See, e.g.*, Lynn M. LoPucki, *A General Theory of the Dynamics of the State Remedies/Bankruptcy System*, 1982 WIS. L. REV. 311, 312 (1982); LYNN M. LOPUCKI & ELIZABETH WARREN, SECURED CREDIT: A SYSTEMS APPROACH (4th ed. 2003).

[91] *See, e.g.*, Fair Debt Collection Practices Act, 15 U.S.C. §1692-1692o (2000); *id.* § 1637 (section of the Truth in Lending Act requiring disclosure for open end credit).

[92] Uwe Reinhart speaks of the "shallow insurance" held by some American patients. Uwe Reinhart, *Reforming the Health Care System: The Universal Dilemma, in* THE SOCIAL MEDICINE READER 451 (Gail E. Henderson, Nancy M.P. King, Ronald P. Strauss, Sue E. Estroff & Larry R. Churchill eds., 1997). *See also* Chad Therune, *Thin Cushion: Fast-Growing Health Plan Has A Catch: $1,000-a-Year Cap*, WALL ST. J., May 14, 2003, at A1. For an account of lifetime maximums from the news media, see Michelle Andrews, *When Insurance Hits the Ceiling*, N.Y. TIMES, Oct. 20, 2002, § 3, at 10.

Medicaid or Medicare recipients may accrue debt from healthcare; government programs are not comprehensive in their coverage, and thus providers may ask beneficiaries to acknowledge their personal liability for uncovered goods or services at the outset.[93] The individual needing health services has a dual role of patient and debtor, with the latter role propelling her into the commercial debtor-creditor world.[94]

When a debtor does not pay on time, a creditor owed money for medical treatment or any other purpose must decide how to respond. The creditor might do nothing. It might add interest and late fees. It might attempt collection or hire one or more debt collectors,[95] any of whom may attempt informal collection methods such as telephone calls and letters. If it cannot find the debtor, the creditor or collection agency may employ skip tracing.[96] The creditor might pursue payment from a guarantor or co-obligor. It could report the debtor's delinquency to credit bureaus.[97] It might file a lawsuit, obtain a judgment, and then garnish the debtor's wages or have the sheriff levy on the debtor's non-exempt property.[98] If it has a security interest in the debtor's personal property, it might repossess and dispose of the property and sue the debtor for any remainder.[99] If it has a security interest in real property, the creditor has similar rights but must go through a different

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[93] Some debt for which patients are charged may not be legitimate, such as when providers of health services and supplies run afoul of "balance billing" prohibitions in Medicare and Medicaid. *See, e.g.*, 42 U.S.C. § 1396a(a)(25)(C) (2000); 42 C.F.R. 447.15 (2002); Maryland Department of Health and Mental Hygiene, Medical Assistance Program, General Provider Transmittal #51 (Feb. 16, 1999) (admonishing health providers for engaging in unlawful balance billing); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, BALANCE BILLING FOR MEDICAL EQUIPMENT AND SUPPLIES 6 (Jan. 2001) (reporting on survey findings that Medicare beneficiaries inappropriately overpaid by $30 million).

[94] For a different analysis of the dual role of patients, see Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL'Y 1 (1998).

[95] Robert M. Frohlich Jr., *Effective Reassignment of Accounts Can Decrease Bad Debt*, HEALTHCARE FIN. MGMT., July 1, 1994, at 36.

[96] *Id.* (identifying use of skip tracing by secondary collection agency placement to collect health provider debts).

[97] The disclosure of credit information by credit bureaus is regulated by the Fair Credit Reporting Act, 15 U.S.C. §§ 1681-1681x (2000), and the recently passed Fair and Accurate Credit Transactions Act of 2003, H.R. 2622, 108th Cong. § 101 (2003) (reauthorizing Fair Credit Reporting Act preemption of state law).

[98] *See generally* Susan Block-Lieb, *Fishing in Muddy Waters: Clarifying the Common Pool Analogy as Applied to the Standard for Commencement of a Bankruptcy Case*, 42 AM. U. L. REV. 337, 353-57 (1993) (providing overview of individual coercive collection process).

[99] U.C.C. §§ 9-607, 9-609, 9-625, 9-626 (2002).

process to foreclose, depending on state law.[100] If the debtor files for bankruptcy, the creditor can exercise the creditors' rights that bankruptcy law offers.[101] The creditor also can refuse to deal with that particular debtor again.

Health care providers, or collectors acting on their behalf, seem to be fairly regular participants in these informal and formal debt collection processes.[102] Accounts sometimes get sent quickly to collection agencies specializing in the full-time business of encouraging payment,[103] and sometimes get sent to a second collection agency for more persistent efforts.[104] Providers may try to collect debts from patients pending

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[100] LYNN M. LOPUCKI & ELIZABETH WARREN, SECURED CREDIT: A SYSTEMS APPROACH 29 (4th ed. 2003).

[101] In a personal bankruptcy case, those rights include filing a claim, seeking relief from the automatic stay, seeking dismissal of the debtor's case for cause, objecting to the debtor's discharge of a particular debt or all debts, objecting to the debtor's proposed treatment of the creditor, or objecting to the exemptions claimed by the debtor.

[102] *See, e.g.*, O'TOOLE, *supra* note 27 (noting that 37.5% of those interviewed and 81% of those with a medical debt reported having been referred to a collection agency for medical bills); Daly et al., *supra* note 13, at 47-49; GRACE ROLLINS, CONNECTICUT CENTER FOR A NEW ECONOMY, UNCHARITABLE CARE: YALE-NEW HAVEN'S HOSPITAL'S CHARITY CARE AND COLLECTIONS PRACTICES (Jan. 2003) (listing examples of aggressive collection attempts, some of which also received coverage in the *Wall Street Journal*), *available at* http://www.ctneweconomy.org/pdf/UC.pdf; CHAMPAIGN COUNTY HEALTH CARE CONSUMERS, HOW MEDICAL DEBT AFFECTS CHAMPAIGN COUNTY CONSUMERS: A COMMUNITY REPORT ON MEDICAL-DEBT-RELATED BANKRUPTCIES AND SMALL CLAIMS LAWSUITS (July 11, 2002), *available at* http://www.shout.net/~geo/pdf/MedicalDebtReport.pdf; News Release, Jay MacDonald, Bankrate.com, *Medical Bills Can Make Your Credit Sick*, *available at* http://www.bankrate.com/brm/news/insur/20020828a.asp (last updated Aug. 12, 2003); Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L. J. 675, 710 (1991); NATIONAL PUBLIC RADIO, KAISER FAMILY FOUNDATION & KENNEDY SCHOOL OF GOVERNMENT, NATIONAL SURVEY ON HEALTH CARE (June 2002) (reporting that 12% are contacted by collection agencies about medical bills), *available at* http://www.kff.org/kaiserpolls/3238-index.cfm; *cf.* Colleen M. Flood, Mark Stabile & Carolyn Hughes Tuohy, *The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care*, 12 HEALTH MATRIX 297, 343 n.177 (2002) (reporting that New Zealand revoked user fee for public hospitals in part due to cost and difficulty of collection).

[103] Daly et al., *supra* note 13, at 47-49. For discussion of whether hospitals engage in an appropriate amount of collection activity, compare Joel S. Weissman, Paul Dryfoos & Katharine London, *Income Levels of Bad-debt and Free-Care Patients in Massachusetts Hospitals: Does Uncompensated Care Serve the Truly Needy?*, HEALTH AFFAIRS, July/Aug. 1999, at 156 (finding very small percentage of high income bad debt cases, "suggesting that Massachusetts hospitals adequately collect debts from patients who are able to pay"), *with* M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 371 (1995) (suggesting hospitals may be soft on bad debt cases to fulfill their charitable obligations, shifting care away from needier patients).

[104] Robert M. Frohlich, Jr., *Effective Reassignment of Accounts Can Decrease Bad Debt*, 48 HEALTHCARE FIN. MGMT. 36 (1994); Ray B. Lefton, *Developing Organizational Charity-Care Policies and Procedures*, 56 HEALTHCARE FIN. MGMT. 52, 54 (2002).

insurance company reimbursement,[105] or from patients who are not legally liable because the provider must accept government program reimbursement as payment in full.[106]

Medical providers face considerable pressure to minimize bad debt.[107] After all, many healthcare providers struggle financially, leading them to close their doors[108] or even file bankruptcy themselves.[109] They struggle even more when

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[105] *See, e.g.*, MacDonald, *supra* note 102 (relaying incidents and describing how patients are caught in crossfire between providers and insurers).

[106] *See supra* note 93.

[107] Frohlich, *supra* note 104; Lefton, *supra* note 104.

[108] For a recent example of a hospital closing its doors, see Anne Barnard, *Flat Line at Waltham Hospital: Financial Pressures Force a City Institution to Close its Doors*, BOSTON GLOBE, July 18, 2003, at A1.

[109] For examples of health provider bankruptcies, see Continental Securities Corp. v. Shenandoah Nursing Home P'ship (*In re* Shenandoah Nursing Home P'ship), 104 F.3d 359 (4th Cir. 1996), *In re* Wilmar Nursing Home, Inc., 996 F.2d 1222 (8th Cir. 1993), Riverside Nursing Home v. N. Metro. Residential Health Care Facility Inc., 977 F.2d 78 (2nd Cir. 1992), Sullivan v. Town & Country Home Nursing Services, Inc. (*In re* Town & Country Home Nursing Services, Inc.), 963 F.2d 1146 (9th Cir. 1991), Matter of Greene County Hosp., 835 F.2d 589 (5th Cir. 1988), Local 144 Hosp. Welfare Fund v. Baptist Med. Ctr. of New York, Inc. (*In re* Baptist Med. Ctr. of New York, Inc.), 781 F.2d 973 (2d Cir. 1986), Corporacion de Servicios Medicos Hospitalarios de Fajardo v. Mora (*In re* Corporacion de Servicios Medicos Hospitalarios de Fajardo), 805 F.2d 440 (1st Cir. 1986), *In re* Martin Place Hosp., 793 F.2d 1292 (6th Cir. 1986), Sisk v. Saugus Bank and Trust Co. (*In re* Saugus General Hosp., Inc.), 698 F.2d 42 (1st Cir. 1983), Scharffenberger v. United Creditors Alliance Corp. (*In re* Allegheny Health, Educ., and Research Foundation), 292 B.R. 68 (Bankr. W.D. Pa. 2003), Holyoke Nursing Home, Inc. v. Health Care Financing Admin. (*In re* Holyoke Nursing Home, Inc.), 273 B.R. 305 (Bankr. D. Mass. 2002), NovaCare Holdings, Inc. v. Mariner Post-Acute Network, Inc. (*In re* Mariner Post-Acute Network, Inc.), 267 B.R. 46 (Bankr. D. Del. 2001), Tabas v. Grennleaf Ventures, Inc. (*In re* Flagship Healthcare, Inc.), 269 B.R. 721 (Bankr. S.D. Fla. 2001), *In re* Greater Southeast Comty. Hosp. Foundation Inc., No. 99-01159, 2001 WL 1138057 (Bankr. D. Colo. June 11, 2001), Hillard Dev. Corp. v. Weinstein (*In re* Richmond Health Care, Inc.), 243 B.R. 899 (Bankr. S.D. Fla. 2000), *In re* Winsted Mem'l Hosp., 249 B.R. 588 (Bankr. D. Conn. 2000), Solow v. United States (*In re* Johnson Rehabilitation Nursing Home, Inc.), 239 B.R. 168 (Bankr. N.D. Ill. 1999), *In re* Union Hosp. Ass'n of the Bronx, 226 B.R. 134 (Bankr. S.D.N.Y. 1998), Robiner v. Beechknoll Nursing Homes, Inc. (*In re* Beechknoll Nursing Homes), 216 B.R. 925 (S.D. Ohio 1997), Hunter v. St. Vincent Medical Ctr. (*In re* Parkview Hosp.), 211 B.R. 619 (Bankr. N.D. Ohio 1997), *In re* Heffernan Memorial Hosp. Dist., 202 B.R. 147 (Bankr. S.D. Cal. 1996), *In re* New Center Hosp., 200 B.R. 592 (E.D. Mich 1996), Geriatrics Nursing Home, Inc. v. First Fidelity Bank, N.A. (*In re* Geriatrics Nursing Home, Inc.), 187 B.R. 128 (D. N.J. 1995), Kings Terrace Nursing Home and Health Related Facility v. New York State Dep't of Social Services (*In re* Kings Terrace Nursing Home and Health Related Facility), 184 B.R. 200 (S.D.N.Y. 1995), Skilled Nursing Prof'l Services v. Sacred Heart Hosp. of Norristown (*In re* Sacred Heart Hosp. of Norristown), 175 B.R. 543 (Bankr. E.D. Pa. 1994), Successor Committee of Creditors Holding Unsecured Claims v. Bergen Brunswig Drug Co. (*In re* Ladera Heights Cmty. Hosp., Inc.), 152 B.R. 964 (Bankr. C.D. Cal. 1993), *In re* St. Joseph's Hosp., 126 B.R. 37 (Bankr. E.D. Pa. 1991), St. Louis South Park II, Inc. v. Missouri Helath Facilities Review Comm. (*In re* Saint Louis South Park II, Inc.), 111 B.R. 260 (Bankr. W.D. Mo. 1990), Russell v. Bean (*In re* Provident Hosp., Inc.), 122 B.R. 683 (D. Md. 1990), *In re* Tidewater Memorial Hosp., Inc., 106 B.R. 885 (Bankr. E.D. Va. 1989), *In re* Mem'l

financially strapped states reduce programs that reimburse healthcare providers.[110]

The debtor-creditor system contains concepts that generally are not taught in health law classes, discussed at health law conferences, or integrated into health care policy debates. They nonetheless are very much a part of health care for many patients and providers. Several specific and potentially negative implications are discussed below.

1. Increased Costs

Credit enables patients to access care without Dr. Hahnemann's required payment-in-advance, but credit is not free. Whether a debtor finances health care through third-party credit or directly with the provider, the cost of health care ultimately may include interest and extra charges. The costs are amplified in bankruptcy even as some debt is discharged. In bankruptcy, debtors pay filing fees,[111] lawyers' fees in the hundreds or thousands of dollars,[112] and probably face more expensive credit after bankruptcy.[113] Consumer credit counseling plans have associated charges as well.

Hosp. of Iowa County, Inc., 82 B.R. 478 (W.D. Wisc. 1988), and *In re* Miami General Hosp., Inc., 81 B.R. 682 (S.D. Fla. 1988). *See generally* Gerben DeJong, Susan E. Palsbo, Phillip W. Beatty, Gwyn C. Jones, Thilo Kroll & Melinda T. Neri, *The Organization and Financing of Health Services for Persons with Disabilities*, 80 MILBANK Q. 261, 283 (2002) (explaining that several of the largest skilled nursing facilities have filed for bankruptcy or closed); Nathalie D. Martin & Elizabeth Rourke, *Les Jeux Ne Sont Pas Fait: The Right to Dignified Long-Term Care in the Face of Industry-Wide Financial Failure*, 10 CORNELL J.L. & PUB. POL'Y 129 (2000); Ann Saphir, *Bankruptcies' Ripple Effects: Chapter 11 Filings Aren't Affecting Operations But Homes' Future Access to Capital Likely to Suffer*, MODERN HEALTHCARE, Mar. 20, 2000, at 50 (noting that 10% of the nation's nursing homes are in chapter 11 bankruptcy according to American Health Care Association).

[110] *See, e.g.*, Robin Toner & Robert Pear, *Cutbacks Imperil Health Coverage for States' Poor*, N.Y. TIMES, Apr. 28, 2003, at A1.

[111] FED. R. BANKR. P. 1006 (2003) (requiring payment of filing fee); 28 U.S.C. § 1930 (2000) (prescribing filing fees of $155 for chapters 7 or 13, in addition to other fees).

[112] *See, e.g.*, Rafael Efrat, *Global Trends in Personal Bankruptcy*, 76 AM. BANKR. L. J. 81, 107 n.126 (2002) (collecting data on attorneys' fees in U.S.); U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF INDIANA, GUIDELINES FOR PAYMENT OF ATTORNEY'S FEES IN CHAPTER 13 CASES, *at* http://www.insb.uscourts.gov/Chapter13FeeGuidlines.pdf (last visited Feb. 5, 2004) (providing guidelines for chapter 13 debtors' attorneys' fees in Southern District of Indiana, and setting $2,000 as the maximum fee, with some exceptions). For a discussion of the disparity of fees and practices related to fees, see Jean Braucher, *Lawyers and Consumer Bankruptcy: One Code, Many Cultures*, 67 AM. BANKR. L.J. 501, 546-548 (1993).

[113] *See, e.g.*, News Release, Myvesta, Secret Financial and Emotional Costs of Bankruptcy Take a Toll on American Families (Mar. 8, 2001) (credit counseling group

As a related matter, using debt to finance health increases the economic vulnerability of the household by raising the stakes if the borrower cannot pay. As noted previously, those who finance health costs with home equity or other secured loans may lose their homes or property if they default on their loans.[114] Even those who finance health care with unsecured debt may lose their assets, as an unsecured creditor can garnish wages or levy assets after going through the formal debt collection process.[115]

2. The Stress of Indebtedness

Anxiety is a health stressor associated with illness.[116]

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estimating post-bankruptcy family pays on average $700 per month more than families without adverse credit events for same transportation and housing due to higher interest rates).

[114] *See generally* JAMES J. WHITE & ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE (5th ed. 2000); LOPUCKI & WARREN, *supra* note 100, at 29. Some health care providers might even seek to secure debts with a lien on proceeds of a personal injury lawsuit. *See* William F. Rohrbach, *Rollover Hippocrates*, WEST VIRGINIA LAWYER, May 1996, at 8 ("If either the patient or attorney refuses to sign the lien, the physician will threaten (and in many cases carry out such threat) to pursue collection of the medical debt before the underlying personal injury litigation has been resolved.").

[115] *See generally* Susan Block-Lieb, *Fishing in Muddy Waters: Clarifying the Common Pool Analogy As Applied to the Standard for Commencing a Case*, 42 AM. U. L. REV. 337, 353-357 (1993) (providing overview of individual coercive collection process).

[116] WILLIAM R. LOVALLO, STRESS & HEALTH; BIOLOGICAL AND PSYCHOLOGICAL INTERACTIONS xii (1997); STAN V. KASL, *Stress and Health Among the Elderly: Overview of Issues, in* STRESS & HEALTH AMONG THE ELDERLY 5-34 (May L. Wykle, Eva Kahana & Jerome Kowal eds. 1992); Ann O'Leary, Shirley Brown & Mariana Suarez-Al-Adam, *Stress and Immune Function, in* CLINICAL DISORDERS AND STRESSFUL LIFE EVENTS 181 (Thomas W. Miller ed., 1997); Margaret Gatz, *Stress, Control, and Psychological Interventions, in* STRESS & HEALTH AMONG THE ELDERLY, *supra*, at 209–22; Steven C. Ames et al., *A Prospective Study of the Impact of Stress on the Quality of Life: An Investigation of Low Income Individuals with Hypertension*, 23 ANNALS OF BEHAV. MED. 112 (2001); Ichiro Kawachi et al., *A Prospective Study of Anger and Coronary Heart Disease: The Normative Aging Study*, 94 CIRCULATION 2090 (1996); James A. Blumenthal, Michael Babyak & Jiang Wei, *Usefulness of Psychosocial Treatment of Mental Stress-Induced Myocardial Ischemia in Men*, 89 AM. J. CARDIOLOGY 164, 167 (2002); MARTIN RYAN, SOCIAL WORK AND DEBT PROBLEMS 36 (1996); DAVID CAPLOVITZ, CONSUMERS IN TROUBLE; A STUDY OF DEBTORS IN DEFAULT, 282-283 (1974); Patricia Drentea & Paul J. Lavrakas, *Over the Limit: The Association Among Health, Race and Debt*, 50 SOC. SCI. & MED. 517 (2000); Richard J. Havlik, Alex P. Vukasin & Stepha Ariyan, *The Impact of Stress on the Clinical Presentation of Melanoma*, 90 PLASTIC & RECONSTRUCTIVE SURGERY 57 (1992); Robert J. Genco, Alex W. Ho, Sara G. Grossi, Robert G. Dunford & Lisa A. Tedesco, *Relationship of Stress, Distress, Disease, and Inadequate Coping Behaviors to Periodontal Disease*, 70 J. PERIODONTOLOGY 711 (1999). Even the popular press has been reporting on the adverse effects of stress. *See, e.g.*, Erica Goode, *The Heavy Cost of Chronic Stress*, N.Y. TIMES, Dec. 17, 2002, at F1 (listed as the most popular article by NYTimes.com readers

Research from a variety of disciplines suggests a correlation between indebtedness or financial trouble and a range of health problems, including suicide.[117] For some debtors, merely owing unmanageable debt is stressful. Creditors' informal and formal debt collection efforts also cause anxiety, although creditors certainly have the legal right to engage in these activities. Thus, using debt to get health care actually may exacerbate illness or instigate other health problems, particularly if the debtor-patient is concerned about getting health care in the future, a difficulty discussed below.

3. Reduced Health Care and Health Maximizing Goods and Services

The fact that providers often are their patients' creditors has implications for the health care relationship. In addition to engaging in debt collection attempts, providers of medical goods and services might refuse to serve patients who have not paid for prior services and have no current method of payment.[118] Concentrating care on paying patients may be part of prudential financial management, but also has consequences

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in the 24 hour period following its publication); David Tuller, *Calculating the Benefits of Managing Stress*, N.Y. TIMES, Jan. 22, 2002, at F7.

[117] Richard Reading & Shirley Reynolds, *Debt, Social Disadvantage, and Maternal Depression*, 53 SOC. SCI. & MED. 441, 443, 450 (2001); Drentea & Lavrakas, *supra* note 116, at 518; DAVID CAPLOVITZ, CONSUMERS IN TROUBLE; A STUDY OF DEBTORS IN DEFAULT 280-83 (1974); Havlik et al., *supra* note 116, at 59-60. *See also* Genco et al., *supra* note 116, at 715-17. For non-U.S. studies considering the debt-health correlation, see, for example, GILLIAN PARKER, GETTING AND SPENDING: CREDIT AND DEBT IN BRITAIN (STUDIES IN CASH AND CARE) (1990); Siegfried Weyerer & Andreas Wiedenmann, *Economic Factors and the Rates of Suicide in Germany Between 1881 and 1989*, 76 PSYCHOL. REP. 1331 (1995); ELAINE KEMPSON, ALEX BRYSON & KAREN ROWLINGSON, HARD TIMES? HOW POOR FAMILIES MAKE ENDS MEET 261-95 (Policy Studies Institute 1994); Simon Hatcher, *Debt and Deliberate Self-Poisoning*, 164 BRIT. J. PSYCHIATRY 111 (1994); Steven Hope, Chris Porer & Bryan Rodgers, *Does Financial Hardship Account for Elevated Psychological Distress in Lone Mothers?*, 49 SOC. SCI. & MED. 1657 (1999); Hilary Graham, *The Socio-economic Patterning of Health and Smoking Behavior Among Mothers with Young Children on Income Support*, 20 SOC. OF HEALTH & ILLNESSES 215 (1998). *See also* Press Release, Consumer Federation of America, *Credit Card Debt Imposes Huge Costs on Many College Students* (June 8, 1999), *at* http://www.consumerfed.org/ccstudent.pdf (reporting on Robert Manning's study on student credit card debt and statements of parents of deceased college students).

[118] *See, e.g.*, SULLIVAN, WARREN & WESTBROOK, AS WE FORGIVE, *supra* note 12, at 167, 174 (discussing possibility that "uninsured debtors may find it impossible to get medical services unless they pay in cash"); Robert J. Blendon & Humphrey Taylor, *Views on Health Care: Public Opinion in Three Nations*, HEALTH AFFAIRS, Spring 1989, at 149, 156 (finding that about 7.5% of American respondents reported they had been denied health care for financial reasons).

for individuals who cannot pay and the health professionals who wish to treat them.[119] Using third-party credit could temporarily extend the patient's access to health care, but in the long term may lead to the same result.

Even if the provider remains willing to serve the patient, patients with pre-existing debts to providers may be reluctant to seek services. They may be embarrassed and fear collection attempts,[120] or may be concerned about incurring more debt.[121] In the Open Society Institute study of individuals using community clinics and resource centers, one in three reported that being referred to a collection agency or owing money for medical care negatively affected their future health-seeking activity; they either would delay seeking medical care, would not return to a prior medical provider, or may use only emergency care for health needs.[122] This point applies not only to medical services, but also to testing, drugs, and assistive medical equipment.[123] The 2001 Consumer Bankruptcy Project

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[119] *See generally* Charles J. Milligan, Jr., *Provisions of Uncompensated Care in American Hospitals: The Role of the Tax Code, The Federal Courts, Catholic Health Care Facilities, and Local Governments in Defining the Problem of Access for the Poor*, 31 CATH. L. 7, 24 (1987) (stating that increased financial pressure on non-profit hospitals has led to decreased charity care).

[120] Daly et al., *supra* note 13, at 42 (reporting that Access Project's Community Access Monitoring Survey found 26% of the people "who owed money to a health care facility said that the debt would deter them from seeking care in the future").

[121] *See, e.g.*, Ke Xu, David B. Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus & Christopher J.L. Murray, *Household Catastrophic Health Expenditure: A Multicountry Analysis*, 362 LANCET 111, 116 (2003) (discussing possibility that poor households will forego care rather than become impoverished: "[m]aking the users of health services pay out of pocket for the services they receive has a potential dual effect at the population level – impoverishing some households that choose to seek services and excluding others from seeking health care"); CAPLOVITZ, *supra* note 117, at 289 (noting that debt problems lead debtor to "so skimp on his budget that he neglects health needs"); Brian Hickey, *Food or Medicine? A Local Doctor Says It's Come to Just That for Many of the Nation's Uninsured*, PHILA. WKLY, Feb. 26, 2003; MacDonald, *supra* note 102 (describing fear of seeking medical care due to bad debtor-creditor experiences in the past); *Second-Class Medicine*, Consumer Reports Feature Report, Sept. 2000, at 1, 10 (discussing deterrence effect on health seeking behavior of incurring debt for health care).

[122] O'TOOLE, *supra* note 27; *see also* Skarbinski et al., *supra* note 26 (reporting that, in survey of households containing sick person in Tbilisi, Georgia, 93% of respondents said costs of health care were major deterrent to obtaining health care, and 10% said cost of health care actually prevented their seeking it).

[123] *See, e.g.*, DeJong et al., *supra* note 109, at 278 (reviewing research revealing that "financial barriers are the most common reason for not having needed assistive equipment" and that large proportion of disabled did not have insurance coverage for the equipment they needed, with many requests being denied by insurers).

will offer further evidence of health related deprivations of financially distressed households.[124]

IV. PROPOSALS TO REDUCE DEPENDENCY ON DEBT-BASED HEALTH CARE FINANCE

A perfect solution to health care finance, whatever that may be, has not emerged, and debt-based approaches are not even a second-best solution. With that in mind, this Part considers the benefits and drawbacks of several ways to reduce dependency on debt and bankruptcy to finance health care. They generally do not depend on changes to existing law, but rather on adaptations to the current framework.

A. Debt, Bankruptcy, and Social Welfare Programs

Some of the studies discussed in this Article reveal indebtedness by quite low-income individuals. Some indebted or potentially indebted low-income people are eligible for, but not enrolled in, state and federal health care programs specifically tailored to their needs.[125] Even without an expansion of eligibility requirements, a higher take-up rate of health programs among eligible individuals might result in the need for fewer debtor-creditor relationships and less debt. Such programs provide care without requiring the patient to incur excessive debt; indeed, assuming everyone follows the rules, patients should not incur much or any debt, at least for the direct costs of medical care. Researchers who study take-up rates of health-related programs should investigate whether those who file medical-related bankruptcy, or those who finance significant health care expenses on credit without filing for bankruptcy, either overlook or consciously reject currently existing alternatives.

Health and related government programs do not necessarily prevent serious financial distress and bankruptcy,

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[124] *See supra* note 25.

[125] *See generally supra* note 73. *See also* Weissman et al., *supra* note 103, at 164 (reporting that enrollment of eligible low income hospital users who currently are considered bad debt could "possibly improve access for patients and relieve their own financial burden"). Some not enrolled have private insurance. Sherry Glied, Dahlia K. Remler & Joshua Graff Zivin, *Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals*, 80 MILBANK Q. 603, 618 (2002) (using 1999 Current Population Survey, estimating that 1.9 million children under 15 who were income eligible for Medicaid held employer sponsored coverage and more than 600,000 held individually purchased insurance).

however. Although the data are sparse, it appears that some individuals file for bankruptcy even while enrolled in other government programs. For example, Jonathan Fisher studied some of the overlap to determine whether personal bankruptcy and income transfer programs are substitutes. Using data from the Panel Study of Income Dynamics, Fisher found that 37.7 percent of the bankruptcy filers in the sample received income from unemployment insurance, Aid to Families with Dependent Children, supplemental security income, food stamps, or a combination of these income transfer programs.[126] This statistic does not address health benefit programs, but Fisher also found no evidence that Medicaid benefits affect the number of bankruptcy filings.[127] The 2001 Consumer Bankruptcy Project will shed additional light on the extent to which bankruptcy filers are enrolled in government health programs, further suggesting that these programs do not entirely succeed in bankruptcy avoidance.[128]

In addition, as a practical matter, full take-up of health programs by the eligible may be financially infeasible in the current economic environment. States across the country are already eliminating enrolled individuals from Medicaid or reducing the available services.[129] In this regard, health programs may be victims of their own "success."

B. *Prudent Financial Management and Greater Information Gathering?*

Although the financial planning practices of households are poorly understood,[130] perhaps the highest income

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[126] JONATHAN D. FISHER, THE EFFECT OF TRANSFER PROGRAMS ON PERSONAL BANKRUPTCY 3 (U.S. Department of Labor, Working Paper No. 346, Oct. 2001), *available at* http://www.bls.gov/ore/pdf/ec010140.pdf. The PSID sample relevant to this study pre-existed the replacement of AFDC with Temporary Assistance to Needy Families. The PSID sample is supposed to be nationally representative, but seems to have far too few bankruptcy filings. *See id.* at 14-15 (discussing low incidence of self-reported bankruptcy in the PSID sample).

[127] *Id.* at 17. Fisher does believe, however, that the generosity of unemployment insurance can affect bankruptcy rates.

[128] *See supra* note 25. As an example of state programs, Pennsylvania has special programs for working disabled people and for disabled children. *See generally* Pennsylvania Health Law Project, *at* http://www.phlp.org (last visited Feb. 5, 2004).

[129] *See, e.g.*, Robin Toner & Robert Pear, *Cutbacks Imperil Health Coverage for States' Poor*, N.Y. TIMES, Apr. 28, 2003, at A1.

[130] *See, e.g.*, ARTHUR B. KENNICKELL, MARTHA STARR-MCCLUER & ANNIKA E. SUNDEN, SAVING AND FINANCIAL PLANNING: SOME FINDINGS FROM A FOCUS GROUP 3-4 (Federal Reserve, Working Paper, January 1996) (noting lack of research on saving,

households both in and out of bankruptcy could make more conservative financial choices *ex ante* to reduce the risk of medical-related financial problems. The household's general financial condition can influence the extent to which medical-related expense precipitates financial disaster. Just as economists suggest saving for post-retirement health care needs,[131] perhaps in today's health care environment people need to save for pre-retirement health care needs if they can afford to do so. To plan appropriately, health plans and higher income households need to take steps to ensure that insurance beneficiaries understand the scope of their coverage. Because medical problems also can reduce one's ability to work, high-income households also should consider purchasing disability insurance coverage, which is expensive but within reach for this segment of the population.[132]

Data from the 1999 Consumer Bankruptcy Project reported in Part II modestly support this proposal because they suggest that a substantial number of ill or injured debtors struggle with other money management or debt problems that perhaps could be avoided with better financial planning. However, because the ill and injured identified these problems at a slightly lower frequency than the non-ill, and because these financial problems could be associated with the medical problems themselves, one must be cautious in interpreting these results.

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and studying focus group of high income households, whose reasons for saving included precautionary motives, although not uniformly), *available at* http://www.federalreserve.gov/pubs/feds/1996/199601/199601pap.pdf.

[131] PAUL FRONSTIN & DALLAS SALISBURY, RETIREE HEALTH BENEFITS: SAVINGS NEEDED TO FUND HEALTH CARE IN RETIREMENT (Employee Benefit Research Institute, Issue Brief No. 254, Feb. 2003).

[132] The U.S. Department of Commerce has estimated that 52.6 million Americans have a disabling condition. *See* JACK MCNEIL, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS: AMERICANS WITH DISABILITIES, HOUSEHOLD ECONOMIC STUDIES (Feb. 2001), *available at* http://www.census.gov/prod/2001pubs/p70-73.pdf. However, many falling within this category would not necessarily consider themselves disabled. *See* DeJong et al., *supra* note 109. Many who apply for disability benefits from the Social Security Administration are initially rejected, and the benefits are quite modest in any event. *See* U.S. SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME DISABILITY PROGRAMS: MANAGING FOR TODAY, PLANNING FOR TOMORROW (Mar. 11, 1999) (on file with author). *See generally* U.S. SOCIAL SECURITY ADMINISTRATION, FAST FACTS AND FIGURES ABOUT SOCIAL SECURITY (June 2003), *available at* http://www.ssa.gov/policy/docs/chartbooks/fast_facts/2003/ff2003.pdf. The 2001 Consumer Bankruptcy Project studies disability coverage among bankruptcy filers, and thus will shed additional light on this issue.

More generally, this proposal, like the low-income household proposal, has multiple shortcomings. First, it will be difficult to encourage higher-income households to reduce their indebtedness given the many incentives for indebtedness, such as the home mortgage interest deduction, and a limited savings ethos.[133] A government truly committed to debt reduction could reconsider and replace such policies with debt-neutral or debt-antagonistic policies, but this has nominal political feasibility. As a related matter, assuming no major changes to health care finance and malpractice lawsuits are made, some medical problems produce bills way too big for even prudent savers.[134]

Furthermore, although understanding the scope of insurance coverage is both admirable and important to good financial planning, households may find this impossible to accomplish given the structure of some benefit plans. To the extent that coverage depends on a finding of medical necessity, coverage is contingent on a discretionary determination made around or after the time that a procedure or health aid is needed.[135] Because this finding cannot be predicted reliably, even higher-income families face barriers to planning for protection against the use of debt and bankruptcy for health care.

C. *Those in the Middle*

Uninsured and under-insured households may be too "rich" for public health programs and too "poor" to save and plan adequately for expensive medical emergencies, rendering the foregoing proposals unhelpful. Following Dr. Hahnemann's lead, medical providers could encourage advance payment with

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[133] *See generally* Melissa B. Jacoby, *Does Indebtedness Influence Health? A Preliminary Inquiry*, 30 J.L. MED. & ETHICS 560, 567 (2002) (describing government encouragement of indebtedness); Wells M. Engledow, *Cleaning up the Pigsty: Approaching a Consensus on Exemption Laws*, 74 AM. BANKR. L.J. 275 (2000) (commenting on government policy to encourage homeownership through mortgage interest tax deductions and low cost federal loans). *See also* Stavins, *supra* note 9, at 20 (reporting based on 1998 Survey of Consumer Finances that "half of unknown households could foresee major expenses in the next five to 10 years . . . but only 29% stated that they were saving for those expenditures").

[134] *See generally* Ian Domowitz & Robert L. Sartain, *Determinants of the Consumer Bankruptcy Decision*, 54 J. FIN. 403, 413 (1999) (evaluating Survey of Consumer Finance data and 1980 bankruptcy case data and finding that "[h]igh medical debt [in excess of 2% of income] has the greatest single impact of any household condition variables in raising the conditional probability of bankruptcy").

[135] *See* DeJong, *supra* note 109, at 274-75.

the incentive of a substantial discount,[136] but this will not be feasible in all instances.[137] Recent research by Professors Elizabeth Warren and Amelia Tyagi suggests that the households in the middle already have committed their incomes to important fixed costs such as housing, transportation, child care, education, and health insurance, leaving little or no cushion for emergencies.[138] For this group, assuming all else remains the same, the question is not how to avoid debt, but rather which type of debt is preferable. Without significant and comprehensive alteration of the health care finance system, the households in the middle are, and likely will remain, caught between the commercial debtor-creditor system and the pursuit of health.

V. CONCLUSION

Indebtedness is nothing new in America,[139] but it deserves special attention when it stems from a visit to the doctor, a lab test, prescription drugs, a hospital stay, medical supplies, or home reconstruction to accommodate disabilities. In the very short term, credit may enhance health access, just like it enhances access to other goods and services, but in the longer term, debt and bankruptcy have the potential to create serious problems.

Some households may have the capacity to avoid health-related indebtedness by seeking out fully covered care if they fit the special categories of low income eligibility, or by buying additional types of insurance and spending more conservatively if they are high income. This Article suggests that pursuing these courses of action might serve patients' and providers' interests better than debt and bankruptcy, although such proposals have limitations and other consequences. Even assuming their viability for some, many households cannot

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[136] *See* Rundle, *supra* note 2 (reporting on medical clinics that operate on up-front cash basis only).

[137] *See, e.g.*, Lefton, *supra* note 104, at 54 (reporting that at Temple East Hospital, uninsured patients ineligible for charity care or unwilling to meet with a financial counselor are offered a more reasonable rate (Medicare-plus-25%) if they make up-front payment).

[138] WARREN & TYAGI, *supra* note 3.

[139] *See, e.g.*, BRUCE H. MANN, REPUBLIC OF DEBTORS: BANKRUPTCY IN THE AGE OF AMERICAN INDEPENDENCE (2002); LENDOL GLEN CALDER, FINANCING THE AMERICAN DREAM: A CULTURAL HISTORY OF CONSUMER CREDIT (1999); PETER J. COLEMAN, DEBTORS AND CREDITORS IN AMERICA: INSOLVENCY, IMPRISONMENT FOR DEBT, AND BANKRUPTCY, 1607-1900 (Beard Books 1999) (1974).

follow either line of advice. Contemporary health policy proposals that address post-retirement prescription drugs[140] and the totally uninsured[141] will not close the pipeline between the health care finance system and the debtor creditor system.

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[140] *See, e.g.*, Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003). The health care finance concerns of the elderly are undoubtedly significant. Researchers recently estimated that one may need as much as $1,458,000 – for health care needs alone – to retire at 65 in 2003 if one has basic Medicare and no supplemental post-retirement health benefits. FRONSTIN & SALISBURY, *supra* note 131. This figure does not even include long term care, which costs approximately $50,000 or more per year. Relying on estimates from the 1999 Medical Expenditure Panel Survey, Fronstin and Salisbury state that Medicare covers only about 50% of health expenses. For data on a general increase in bankruptcy filings among individuals 65 and older, see Sullivan, Thorne & Warren, *supra* note 7.

[141] *See, e.g.*, John Kerry for President, *Affordable Health Care for Every American*, *at* http:///www.johnkerry.com/issues/healthcare (proposing a plan to provide health care to the 40 million uninsured Americans who have no coverage) (last visited Feb. 5, 2004); Dean for America, *Promoting American Health*, *at* http://www.deanforamerica.com/site/PageServer?pagename=policy_statement_health# (proposing methods to make insurance available and affordable) (last visited Feb. 5, 2004).