

Medical Bankruptcy Reform: A Fallacy of Composition

by

Robert J. Landry, III*

and

Amy Y. Landry**

ABSTRACT:

Congress is considering adding special provisions to the Bankruptcy Code for individuals with medical debt. The pending legislation creates preferential rules for “medical bankruptcies.” The reform is based on a premise that most consumer bankruptcies are caused by medical debt, so that most consumer bankruptcy cases are “medical bankruptcies.” The authors analyze this premise and show that although many debtors have some medical debt, most debtors with medical debt are not “medical bankruptcies.” The premise of the pending legislation is shown to be nothing more than a classic case of “fallacy of composition” and the reform will lead to abuse of the relief afforded under the Bankruptcy Code.

I. INTRODUCTION

Rhetoric is powerful. It is particularly powerful in debates that invoke emotion, anger and raise serious moral questions. Policymakers often latch on to facts asserted in a policy domain, whether true or not, and characterize them in ways—through an effective use of rhetoric—to propel certain initiatives onto the agenda. This is the case in the healthcare and bankruptcy policy domains. Policymakers in both domains use data from their respective fields to advance reforms in the other domain,¹ often couching their arguments in terms of clear empirical causal connections.

For example, in the context of the healthcare reform debate, consumer bankruptcy reform has become a sub- issue. In the 2009 State of the Union address Barack Obama said, “we must also address the crushing cost of health care. This is a cost that now causes a bankruptcy in America every 30 seconds.”² The President took the rhetoric a step further to assert that health care costs not only cause bankruptcy, but also will cause 1.5 million Americans to lose their homes. President Obama said, “[t]he crushing costs of health care causes a bankruptcy in America every 30 seconds. And by the end of this year, it could cause 1.5 million Americans to lose their homes.”³ This assertion that healthcare costs are *the* cause of consumer bankruptcy has been repeated over and over again, to such an extent that is accepted as fact without any qualification or context placed on the assertion.⁴

The connection between healthcare costs and consumer bankruptcy has been used as a justification for several bills pending in Congress that relax the requirements in the Bankruptcy Code for debtors with medical debts, i.e. “medical bankruptcy.” The problem is that the underlying justification—a clear causal connection between medical debts or healthcare costs and most consumer bankruptcy filings is not as strong as the political rhetoric proclaims. Medical debt does not necessarily lead to bankruptcy. But rather, “[m]edical bankruptcy is at the extreme end of the spectrum of medical debt.”⁵ Nor does a debtor with medical debt necessarily warrant characterizing it as a medical bankruptcy. Simply because some debtors with medical debt may justifiably be characterized as a medial bankruptcy, does not mean all debtors with medical debt are medical bankruptcies—a classic case of the “fallacy of composition.”⁶

The result is a legislative agenda in the bankruptcy policy domain that does not address the root causes of consumer filings. The medical bankruptcy reform proposed is a relaxation of the requirements for filing for bankruptcy relief for debtors with medical debt. The reform does not address, assuming medical debts are the cause of the majority of consumer bankruptcies, the root cause of unpaid medical debt. Likewise, even if medical debt is not the root causal factor, but rather a factor among many others such as divorce and unemployment, of consumer bankruptcy filings, medical bankruptcy reform does nothing to mitigate the incidence of consumer filings.

This paper addresses the causal connection between medical debts and consumer bankruptcies, and the validity of that linkage based on empirical research in the field. Next we analyze, assuming medical bankruptcy is prevalent and

* Assistant Professor of Finance, College of Commerce and Business Administration, Jacksonville State University, Jacksonville, AL

** Assistant Professor, Department of Health Services Research, Management and Policy, University of Florida, College of Public Health and Health Professions, Gainesville, FL

widespread, the medical bankruptcy reform bills currently pending in Congress exploring the effectiveness of the substantive provisions. Following this Introduction is an overview of the current state of consumer bankruptcy in the U.S. and a brief summary of the medical bankruptcy reform. Part III explores the empirical research on medical bankruptcies, the adequacy of the current system, and problems with the reform. Part VI concludes with a review of policy implications and suggestions for future research.

II. OVERVIEW OF CONSUMER BANKRUPTCY AND PROPOSED MEDICAL BANKRUPTCY REFORM

A. Consumer Bankruptcy in the U.S.

Most consumer bankruptcies are under Chapter 7 or Chapter 13.⁷ Chapter 7 provides debtors, in most cases, a discharge of their debts, provided they liquidate any non-exempt assets.⁸ Under Chapter 13 a debtor can retain its non-exempt assets, in exchange for repaying a portion of its debts, at least as much as would be paid in a Chapter 7 case, through a court approved repayment.⁹ After completion of the plan, the debtor will receive a discharge of the remaining unsecured debts once the plan is completed.¹⁰

On October 17, 2005, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (Reform Act)¹¹ went into effect.¹² The Reform Act was the most significant overhaul to the Bankruptcy Code¹³ (Code) since 1978.¹⁴ The Reform Act did not modify the two primary avenues for consumers to seek relief: Chapter 7 or Chapter 13. However, the Reform Act created procedural hurdles designed to limit the number of Chapter 7 filings by driving more individual consumer debtors to Chapter 13 through a means test.¹⁵ Prior to the Reform Act individuals largely chose between Chapter 7 or Chapter 13 based on the circumstances and legal consequences of the choice. Most consumer filings were under Chapter 7 and in most Chapter 7 cases there was no return to unsecured creditors. Debtors now must qualify for the relief they request. In effect the system prior to the Reform Act was an income-tax type of system with debtors largely self reporting, but was transformed into a welfare type system that requires documentation to qualify for the relief requested.¹⁶ The primary tool to steer debtors from Chapter 7 to Chapter 13 is the means test.¹⁷

The means test requires an examination of the debtor's monthly income in comparison with the median income in the state they reside.¹⁸ If the debtor's income is higher than the median income, then the debtor must complete a detailed analysis of the debtor's expenses to determine if the debtor has sufficient funds to repay creditors.¹⁹ If the debtor has sufficient funds the case is presumed an abuse.²⁰ Absent the debtor rebutting the presumption of abuse, the case is due to be dismissed.²¹

B. Medical Bankruptcy Reform

Currently there are bills pending in both the House of Representatives and Senate, the Medical Bankruptcy Fairness Act ("MBFA"),²² that create a special category of bankruptcy relief for medical debtors. The MBFA creates special provisions for a newly defined class of Chapter 7 debtor, the "medically distressed debtor."²³

To be classified as a medically distressed debtor, an individual must fit into one of three situations. First, an individual that has incurred or paid \$10,000 or 10 percent of their adjusted gross income in medical debt during any consecutive 12-month periods in the 3 years prior to filing bankruptcy for the debtor, a dependent or non-dependent immediate family member, which has not been paid by a third party qualifies as a medically distressed debtor.²⁴ Second, if an individual is a member of a household in which one of the household members lost their domestic support obligation income due to a medical problem of the person obligated to pay the support for 4 or more weeks during any consecutive 12-month period in the last 3 years.²⁵ Third, an individual can be a medically distressed debtor if they lost work due to a medical condition or for caring for a nondependent immediate family member for at least 30 days during any consecutive 12-month period in the last 3 years.²⁶

If a debtor qualifies as a medically distressed debtor they are afforded three specific protections not afforded to other Chapter 7 consumer debtors. First, the medically distressed debtor is afforded enhanced exemptions.²⁷ Rather than being afforded the real property exemption under the Code of \$20,200²⁸ or applicable state law,²⁹ medically distressed debtors are afforded a homestead exemption of up to \$250,000.³⁰ Second, the requirement of pre-petition credit counseling³¹ would be waived for medically distressed debtors.³² And, third, the means-test,³³ a cornerstone of the Reform Act,³⁴ would not be applicable to medically distressed debtors.³⁵

III. FAULTY PREMISE: IS MEDICAL BANKRUPTCY REFORM REALLY NEEDED?

A. Medical Bankruptcy

Medical bankruptcy reform is premised on two purported facts: (1) a clear connection between healthcare costs and most consumer bankruptcy filings, and (2) the assertion that the current consumer bankruptcy system is not providing

adequate relief to debtors with medical debt. On the first premise, it is clear that healthcare costs do contribute to filing consumer bankruptcy. Disagreement lies in degree of influence that medical occurrences have on consumer bankruptcy.

A 2005 study by Himmelstein and colleagues suggests that medical problems contribute to over half of all consumer bankruptcy filings.³⁶ This estimate is a bit extreme as it actually inflates the causal effect that medical issues actually have on bankruptcy filing rates. Critics assert that Himmelstein's definition of medical bankruptcy- any debtor with \$1000 or more in medical debt during the last two years of filing bankruptcy- is overly broad in light of average annual private medical expenditures nearly \$2500.³⁷ The very low threshold required to be classified as a medical bankruptcy, coupled without any distinction made for the magnitude of the medical debt in relation to other debts lead to coding many filings as medical bankruptcies when in fact they may not really be medical bankruptcies.³⁸

In 2006, Dranove and Millenson, in response to the Himmelstein study, suggest that medical related expenses more likely contribute to around 17% of consumer filings, and that the Himmelstein study neglected to incorporate the effects that job loss, existing debt, and housing costs have on filings.³⁹ The key concern that Dranove and Millenson proffer is simple: "All debt contributes to bankruptcy...[but]...Himmelstein and colleagues never establish the relative importance of medical bills in bankruptcy..."⁴⁰

Other studies and reports shed doubt on the prevalence of medical bankruptcies. The United States Trustee Program reported that 90% of consumers filing for bankruptcy have medical debt of less than \$5,000, accounting for only 13% of all unsecured debt.⁴¹ A 2000 report of the Congressional Budget Office cites medical bills, divorce, loss of income related to unemployment, and poor debt management as causal factors for bankruptcy filings.⁴²

Judging from the evidence, the most likely case seems that individuals with existing debt are pushed over the financial edge when a medical problem occurs. Coupling the lost wages resulting from time away from work with the addition of medical debt, as well as other exogenous factors, certain individuals may not be able to meet their existing financial obligations, and subsequently file for bankruptcy protection.⁴³ This suggests that a medical problem might exacerbate an individual's already tenuous financial picture to the point of bankruptcy, but does not suggest that medical problems are that primary cause most bankruptcy filings.⁴⁴

Even though there is not much agreement about the number of medical bankruptcies, it is crystal clear that the rhetoric assertions that there is a medical bankruptcy every 30 seconds is simply not true. The math is simple: "this would mean more than 1 million per year [bankruptcies] when there were less than 825,000 actual American bankruptcies!"⁴⁵

B. Adequacy of Current System

The second premise, that consumer bankruptcy is not providing adequate relief to medical debtors, is not clear. Unsecured medical debts are treated exactly like other unsecured debts in Chapter 7 and Chapter 13. In the typical Chapter 7 case unsecured debts, including medical debts, are discharged.⁴⁶ In Chapter 13 medical debt is treated the same as other unsecured debts. Under a Chapter 13 plan unsecured debts may be paid back in full, in part or not at all. The payments are based on an analysis of income and expenses, a liquidation analysis, and ultimately based on what the debtor can afford.⁴⁷

It has been argued that means test does not distinguish medical debtors from other debtors and are not given any protection over and above other debtors.⁴⁸ That is true. All debtors with unsecured debt are treated the same under the means test. The means test is designed to serve as a filter to detect abusive cases based on an ability to repay unsecured debts. Only above-median debtors that are able to repay unsecured creditors would be subject to the presumption of abuse. In that instance they would be dismissed or convert to Chapter 13 to repay some debts and receive a discharge of the remaining unsecured debts, including medical debts. Debtors with medical debt that are below the median income would not be subject to the presumed abuse and would receive a discharge. Above-median debtors that cannot repay would not be subject to the presumed abuse and receive a discharge. It is only above-median debtors with the ability to repay debts that will not receive a Chapter 7 discharge. They can seek relief under Chapter 13.

There is no logical basis to permit debtors that can repay their debts to receive a discharge. Whether the debt is medical or not, is not the inquiry. Debtors that can repay some of their debts should be required to do so. And those that cannot will obtain a discharge. The current system is adequate and consistent with well entrenched bankruptcy policy that balances a fresh start with the interest of creditors.⁴⁹

C. Problems with Medical Bankruptcy Reform

As outlined in Part II above, the MBFA modifies the treatment of a debtor classified as a "medically distressed debtor." Each area of reform will be addressed and the problems associated with each specific reform.

1. The Definition of a "Medically Distressed Debtor"

The MBFA definition of medically distressed debtor is overly broad and riddled with opportunities for manipulation by debtors. There are several ways to fit in this classification, but the primary way is for an individual to have incurred or paid \$10,000 or 10 percent of their adjusted gross income in medical debt during any consecutive 12-month

periods in the 3 years prior to filing bankruptcy for the debtor, a dependent or non-dependent immediate family member, which has not been paid by a third party.⁵⁰ The reality is that many debtors will fit in this category, even if they have a relatively small portion of medical debt. Sixty percent of debtors have between \$24,000 and \$36,000 in income and had on average about \$20,000 in credit card debt.⁵¹ Therefore, if typical filers had medical debt of \$2,400 to \$3,600, they would fit into the category of medically distressed debtor even if their primary debts were consumer oriented debts.⁵²

2. Enhanced Exemptions

The MBFA enhances the exemption rights for medically distressed debtors. Rather than being afforded the real property exemption under the Code of \$20,200⁵³ or applicable state law,⁵⁴ medically distressed debtors will have a homestead exemption of up to \$250,000.⁵⁵ The empirical research on the impact of homestead exemption levels and consumer filing is mixed.⁵⁶ Some research has shown that higher exemption levels actually lead to lower Chapter 13 rates and leads to higher Chapter 7 rates.⁵⁷ These results are logical because higher exemption protect the homestead from creditors so there is less of a need to seek relief under Chapter 13 to keep a home if the equity is protected under the exemption. Other research has shown that higher exemption levels lead to higher consumer filings overall.⁵⁸ The findings support the likelihood of MBFA encouraging more Chapter 7 filings. If more equity in a home is protected by filing bankruptcy than the typical state-level exemption, then individuals will have an economic incentive to file for Chapter 7. What will occur is that higher income debtors, with greater equity positions in their homes, that can afford good legal counsel will be able to plan and strategically position themselves to be able to qualify as a medically distressed debtor and retain assets, over and above what is necessary for support and maintenance, that could be used to repay creditors.

3. Waiver of Pre-Petition Credit Counseling

The MBFA acts waives the pre-petition credit counseling that is required for most consumer debtors.⁵⁹ Credit counseling of consumers was intended by Congress to provide an opportunity to learn of the consequences of filing for bankruptcy prior to deciding to actually file.⁶⁰ Consumer debtors are required to obtain a certificate evidencing pre-petition credit counseling prior to filing or meet a statutory exemption and fulfill the requirement within 30 days of filing.⁶¹ This requirement can be waived in very limited circumstances, such as active military duty in combat zone, incapacity or disability.⁶² MBFA adds the medically distressed debtor to the list of individuals subject to the waiver.

The argument for the waiver for the medically distressed debtor applies to virtually all debtors. Early anecdotal evidence indicates that by the time consumers obtain the counseling, they are in such dire straits that bankruptcy is the only viable alternative.⁶³ If this anecdotal evidence is correct, the requirements should be eliminated for all debtors, not just the medically distressed debtor.

4. Waiver of Means-Test

The fundamental purpose behind the Reform Act was to reduce the number of Chapter 7 consumer-bankruptcy filings, which have continued to grow at dramatic rates each year over the last decade.⁶⁴ The means test was designed to hold people more accountable for their debts and give to creditors more of what they are owed. The basic goal was to shut the door on Chapter 7 for consumer debtors can afford to repay all or some of their debts. Creating a special category for medical debtors so they are exempt from the requirements of the means test, without any regard to whether the debtor can actually repay some of their debts or considering the magnitude of the medical vs. consumer debt, is inconsistent with the policy goals of implementing the means test in 2005.

Consideration of how the means test works is needed to appreciate the potential for abuse. A presumption of abuse in Chapter 7 cases is determined by the debtor's ability to repay a portion of general unsecured debts. This computation is based on the debtor's current monthly income, less allowed deductions, utilizing an IRS standard for expenses. If the debtor's current monthly income is at or below the median family income in the debtor's state, there is no presumption that the debtor is abusing the system. If the debtor's current monthly income is above the median family income in the debtor's state, then a presumption of abuse arises in two instances. First, if the debtor's current monthly income minus expenses is greater than \$167, it is assumed that \$10,000 over a 60-month period will be sufficient to fund a plan regardless of how much general unsecured debt exists. Second, if the debtor's current monthly net income lies between \$100 and \$166.67 and the product after multiplying by 60 results in at least 25% of the debtor's general unsecured claims, then it is presumed to be an abuse of the relief system under bankruptcy. The presumption of abuse can be rebutted by showing special circumstances.

Medically distressed debtors would not be subject to this test at all, regardless of their income or the magnitude of the other debts a debtor may have. The MBFA would create a free-pass for such debtors. Higher income debtors, those that are currently subject the requirements of the means test, would be able to "walk away from not only their medical debts, but also other debts such as credit card debts."⁶⁵

We can all agree that healthcare costs are a causal factor of consumer bankruptcy. Regardless of the disagreement on extent of healthcare costs actually causing bankruptcy, if we step back from the rhetoric and assume that half of bankruptcies are caused by illness or medical bills, bankruptcy law is not the problem. Professor Warren, a co-researcher on some of the most persuasive empirical studies showing a causal connection between healthcare costs and bankruptcy, wrote that prior to the passage of the Reform Act in 2005: “The problem is not in the bankruptcy laws. The problem is in the health care finance system and in chronic debates about reforming it.”⁶⁶ This statement is as true today as it was then. Rather than continually tinkering with the bankruptcy system, policymakers need to confront, in a meaningful way, the other policy domains that are connected to bankruptcy. Similarly, scholars need to focus on those policy connections in their research.⁶⁷ As Professor Warren recognizes, healthcare reform should be a priority, but so should reforms that increase financial literacy, increase access to high quality education or minimum wage laws. The medical bankruptcy reform is just another incremental reform to consumer bankruptcy that fails to address the root causes of consumer bankruptcy. It is a reform that is based on a fallacy of composition. Such a reform is misguided and leaves the social safety net in the same tattered state as it found it.

Footnotes

¹ Senator Max Baucus working on a health care bill used bankruptcy filing rates to support health care reform. He stated: “And, you know, one -- if the coverage is at least 65 percent it's going to probably reduce the incidence of bankruptcies.” *Sen. Max Baucus Holds a Markup on Health Care Reform*, Part 5, CQ Capital Transcripts, Sept. 29, 2009 (2009 WLNR 19277273).

² For a complete text of the Address, see <http://www.presidency.ucsb.edu/ws/index.php?pid=85753> (last visited, June 1, 2010).

³ Mara Liasson, NPR, White House Spotlights Health Care, (March 3, 2009), available at: <http://www.npr.org/templates/story/story.php?storyId=101368678>. The Obama Administration repeatedly has relied on this connection. For example, see *White House Forum on Health Reform*, Washington, DC, Report issued March 30, 2009, pp. 1.

Many other politicians have asserted the same proposition. Senator Ted Kennedy wrote, “[e]very 30 seconds in the United States a family is forced into bankruptcy because of unexpected medical expenses.” Senator Edward M. Kennedy, *Health Care as a Basic Human Right: Moving from Lip Service to Reality*, 22 HARV. HUM. RTS. J., 165,166 (Summer 2009).

A countless number of scholars have asserted the same connection. See Katherine L. Record, Note, *Wielding the Wand Without Facing the Music: Allowing Utilization Review Physicians to Trump Doctors’ Orders, But Protecting Them from the Legal Risk Ordinarily Attached to the Medical Degree*, 59 DUKE L. J. 955, 964 (2010)(“Without drastic reductions in health care spending, an unprecedented number of Americans will face bankruptcy merely by seeking necessary treatment.”).

⁴ Even our own members of Congress assume the clear linkage exists without any question. Senator Max Baucus stated, “I saw figures someplace, every 30 seconds, someone in America goes into bankruptcy due to medical care costs or at least it's medical cost related.” *Sen. Max Baucus Holds a Markup on Health Care Reform*, Part 5, CQ Capital Transcripts, Sept. 29, 2009 (2009 WLNR 19277273). Congressman Phil Hare touted the same conclusions on THE ED SHOW recently. Congressman Hare stated “I care about the price that the people are paying when they lose their home every 30 seconds because of health care. Every 30 seconds in this country, Ed, a bankruptcy.” MSNBC News, THE ED SHOW, January 26, 2010 (2010 WLNR 1682152).

⁵ Robert W. Seifert and Mark Rukavina, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, 25(2) HEALTH AFFAIRS-WEB EXCLUSIVES w89-92, February 28, 2006, available at: <http://content.healthaffairs.org/cgi/content/full/25/2/w89>.

⁶ The fallacy of composition assumes “without proper warrant that what is true for individual members of a group is true for the entire group.” See Philip Harvey, *Is There a Progressive Alternative to Conservative Welfare Reform?* 15 GEO. J. ON POVERTY L. & POL’Y 157, 170 (Summer 2008). See also, Donald A. Dripps, *The Fourth Amendment and the Fallacy of Composition: Determinacy Versus Legitimacy in a Regime of Bright-Line Rules*, 74 MISS. L.J. 341, 348 (2004)(“In his Sophistical Refutations, Aristotle described what has come to be known as the fallacy of composition, i.e., confusing the distributive and collective senses of a class. He gives several examples. A sitting man can walk, and a walking man can stand; ergo a man can walk and sit at the same time. A man can carry each of several burdens; ergo he can carry all of them at once.”)(citations omitted); Einer Elhauge, *Defining Better Monopolization Standards*, 56 STANFORD L. REV. 253, 339 (2003)(“The fallacy of composition is the assertion that, if something is true for individual members of a group, then it must be true for the group as a whole.”)(citations omitted).

⁷ A very small number of consumer bankruptcy cases are filed under Chapter 11. See Elijah M. Alper, *Opportunistic Informal Bankruptcy: How BAPCPA May Fail to Make Wealthy Debtors Pay Up*, 107 COLUM. L. REV. 1908, 1913, fn.35 (2007).

⁸ See Lars Lefgren and Frank McIntyre, *Explaining the Puzzle of cross-State Differences in Bankruptcy Rates*, 52 J.L. & ECON. 367, 370-371 (2009).

⁹ *Id.*

¹⁰ *Id.*

¹¹ Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, 119 Stat. 23 (2005)[hereinafter Reform Act].

¹² Some provisions of the Reform Act were effective immediately upon enactment. For example, several amendments to the homestead exemptions and delay in granting a discharge in limited situations were effective immediately. See 11 U.S.C. §§ 522(o), (p), (q), 727(a)(12), 1141(d), 1228(f), 1328(f). For a complete list of the effective dates, see WILLIAM HOUSTON BROWN & LAWRENCE AHERN III, 2005 BANKRUPTCY REFORM LEGISLATION WITH ANALYSIS (2005), Section II.C.

¹³ 11 U.S.C. §§ 101–1527 (2006). Unless otherwise noted, all references to Bankruptcy Code, code, or section are to Title 11 of the United States Code, including amendments made by the Reform Act.

¹⁴ Bankruptcy Reform Act of 1978, Pub. L. No. 95-598, 92 Stat. 2549 (1978). The Bankruptcy Reform Act of 1978 took effect on October 1, 1979. *Id.* § 402(a), 92 Stat. at 2682.

¹⁵ See Bud Stephen Tayman, *After BAPCPA: New Challenges for Chapter 13 Filers and their Attorneys*, ASPATORE, 2010 WL 3834,*2 (January 2010). See also Tally M. Wiener and Nicholas B. Malito, *On the Nature of the Chapter 7 Trustee Fee*, J. BANKR. L & PRAC. 2 ART. 3 (April 2009).

¹⁶ See Andrew P. MacArthur, *Pay to Play: The Poor's Problems in BAPCA*, 25 EMORY BANKR. DEV. J. 407, 419 (2009).

¹⁷ 11 U.S.C. § 707(b)(2)(2006).

¹⁸ See Lauren E. Tribble, Note, *Judicial Discretion and the Bankruptcy Abuse Prevention Act*, 57 DUKE L. J. 789, 800 (2007).

¹⁹ *Id.* at 800-801.

²⁰ *Id.*

²¹ *Id.* at 802-803.

²² Medical Bankruptcy Fairness Act of 2009, S. 1624, 111th Cong. [hereinafter MBFA].

²³ MBFA, § 2(a)(1).

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ MBFA, § 3(a).

²⁸ 11 U.S.C. § 522(d)(2006).

²⁹ States can opt out of the federal exemptions. See 11 U.S.C. § 522(b)(3)(2006).

³⁰ MBFA, § 3(a).

³¹ 11 U.S.C. § 109(h)(1)(2006).

³² MBFA, § 5.

³³ 11 U.S.C. § 707(b)(2)(2006).

³⁴ Evan J. Zucker, Note, *The Applicable Commitment Period: A Debtor's Commitment to a Fixed Plan*, 15 AM. BANKR. INST. LAW REV. 687, 711 (Winter 2007)(“The cornerstone of the BAPCPA reform was the creation of the chapter 7 means test.”).

³⁵ MBFA, § 4.

³⁶ See David U. Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5-63, available at <http://www.content.healthaffairs.org/webexclusives>. The authors provide a range between 46.2 to 54.5 percent of bankruptcies are medical. *Id.*

³⁷ Todd J. Zywicki, *An Economic Analysis of the Consumer Bankruptcy Crisis*, 99 NORTHWESTERN UNIV. L. REV. 1463, 1518-19 (2005).

³⁸ *Id.*

³⁹ David Dranove and Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, HEALTH AFFAIRS- WEB EXCLUSIVES Feb. 28, 2006, available at: <http://content.healthaffairs.org/cgi/content/full/25/2/w74>.

⁴⁰ David Dranove and Michael L. Millenson, *Medical Bankruptcy: Dranove And Millenson Respond*, HEALTH AFFAIRS- WEB EXCLUSIVES, February 28, 2006, available at: <http://content.healthaffairs.org/cgi/content/full/25/2/w93>.

⁴¹ *Id.* at W78.

⁴² Congressional Budget Office, *Personal Bankruptcy: A Literature Review* (Washington: U.S. Congress, 2000).

⁴³ The traditional model of consumer bankruptcy recognizes that consumer bankruptcy results from a convergence of facts. The traditional model views consumer bankruptcy as an effort to “deal with insoluble financial problems brought on by exogenous factors such as heavy indebtedness or sudden and unexpected income or expense shocks, such as unemployment, medical problems, or divorce.” See Todd J. Zywicki, *An Economic Analysis of the Consumer Bankruptcy Crisis*, 88 NORTHWESTERN UNIV. L. REV. 1463, 1465 (Summer 2005)

⁴⁴ This calls into question whether a national health insurance solution to health reform would have any real influence on the country's consumer bankruptcy rate.

⁴⁵ David McKalip, *Rationed Care is Bad Care*, ST. PETERSBURG TIMES, 8A, APRIL 11, 2009.

⁴⁶ Marthur, Aparna, Statement before the United States Senate Committee on the Judiciary Subcommittee on Administrative Oversight and the Courts Hearing on “Medical Debt: Can Bankruptcy Reform Facilitate a Fresh Start?”, at page 7 (October 20, 2009).

⁴⁷ *Id.* at 8.

⁴⁸ Pottow, Joahn A. E., Testimony, United States House of Representatives Committee on the Judiciary Subcommittee on Commercial and Administrative Law: “Medical Debt: Is Our Healthcare System Bankrupting Americans?” at page 6 (July 28, 2009)

⁴⁹ Under bankruptcy law, there are two goals of consumer bankruptcy. First, consumer bankruptcy is designed to provide an equitable distribution of assets among creditors; and second, it is designed to provide debtors a fresh start via a discharge of their debts.

⁵⁰ *Id.*

⁵¹ Marthur, *supra* note 46, at 9-10.

⁵² *Id.*

⁵³ 11 U.S.C. §522(d)(2006).

⁵⁴ States can opt out of the federal exemptions. See 11 U.S.C. §522(b)(3)(2006).

⁵⁵ MBFA, § 3(a).

⁵⁶ Robert J. Landry, III, *An Empirical Analysis of the Causes of Consumer Bankruptcy: Will Bankruptcy Reform Really Change Anything?*, 3 RUTGERS BUS. L.J. 2 , 18 & 25 (2006).

⁵⁷ *Id.* at 40.

⁵⁸ Marthur, *supra* note 46, at 12.

⁵⁹ 11 U.S.C. §§ 109(h), 521(b) (2006). Bankruptcy Code § 109(h)(1) provides as follows:

an individual may not be a debtor under this title unless such individual has, during the 180-day period preceding the date of filing of the petition by such individual, received from an approved nonprofit budget and credit counseling agency described in section 111(a) an individual or group briefing (including a briefing conducted by telephone or on the Internet) that outlined the opportunities for available credit counseling and assisted such individual in performing a related budget analysis.

⁶⁰ The legislative history clearly states the intended purpose of the pre-petition credit counseling:

The legislation’s credit counseling provisions are intended to give consumers in financial distress an opportunity to learn about the consequences of bankruptcy – such as the potentially devastating effect it can have on their credit rating (citation omitted) before they decide to file for bankruptcy relief.

H.R.Rep. No. 109-31, Part 1 at 18 (2005), U.S. Code Cong. & Admin. News 2005, p. 104.

⁶¹ Robert J. Landry, III and Nancy H. Mardis, *Consumer Bankruptcy Reform: Debtors’ Prison Without Bars or “Just Desserts” for Deadbeats?* 36 GOLDEN GATE U. L. REV. 91, 107 (2006).

⁶² *Id.*

⁶³ GENERAL ACCOUNTING OFFICE, PERSONAL BANKRUPTCY: METHODOLOGICAL SIMILARITIES AND DIFFERENCES IN THREE REPORTS ON DEBTORS’ ABILITY TO PAY at 4 , Pub. No. GAO/T-GGD-99-58, (1999).

⁶⁴ Michelle J. White, *Bankruptcy and Small Business*, 24 REG., Summer, at 18.

⁶⁵ Marthur, *supra* note 46, at 11.

⁶⁶ Elizabeth Warren, Sick and Broke, A23 THE WASHINGTON POST FEBRUARY 9, 2005.

⁶⁷ See e.g., Katherine Porter, *The Potential and Peril of BAPCPA for Empirical Research*, 71 MO. L. REV. 963, 1078 (2006)(The author recognizes a whole host of policy areas that intersect with the bankruptcy system and the importance of empirical research on the relationship between those areas and consumer bankruptcy.)