February 13, 2005

My name is Anne L. Halverson. I am a 21-yr-old single mother of a one-year-old son, Aidan. I take motherhood very seriously and I take my employment seriously. In order to be employed and provide the best childcare environment for my son, I rely on a state funded child care subsidy. That means, based on my income, I pay a percentage of my son's child care expenses and the State of Minnesota subsidizes the rest.

My son thrives at his day care center, Noah's Ark, in Hopkins, MN. He is cared for by well trained providers who, like me, want him to meet his growth milestones, be happy and well adjusted, understand about sharing, learn about tolerance, and be prepared for kindergarten. My son and I also rely on state subsidized health care. His pediatric clinic monitors his growth, advises me about his medical needs and has helped me become a confident parent. I know how fortunate I am to live in a state that values children by providing these opportunities.

Minnesota's governor, Tim Pawlenty, has proposed a budget that will slash child care and health care subsidies for single mothers like me and our children. Without the aid of these subsidies, I will be forced to quit my job and surrender opportunities to advance in the workforce. I will have to stay at home with my child and apply for welfare benefits.

If you believe in the right of all to have adequate healthcare and if you support parents who want their children in safe, regulated childcare centers; parents who are proud to be part of Minnesota's workforce, please sign the attached petition. I will present this petition when I speak before a Minnesota Senate Committee that is convening on Wednesday, February 16, at the Minnesota State Capital.

Thank You,

Anne L. Halverson

Anne L. Halverson
33 6th Ave. No. #212
Hopkins, MN 55343

We, the undersigned, want the State of Minnesota to continue to value the health and welfare of its children by providing adequate health care coverage and child-care subsidies for low income families.

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PETITION: We, the undersigned, want the State of Minnesota to continue to value the health and welfare of its children by providing adequate health care coverage and child-care subsidies for low income families.

Signatures 1 to 44 of 168

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PETITION: We, the undersigned, want the State of Minnesota to continue to value the health and welfare of its children by providing adequate health care coverage and child-care subsidies for low income families.

Signatures 45 to 87 of 168

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PETITION: We, the undersigned, want the State of Minnesota to continue to value the health and welfare of its children by providing adequate health care coverage and child-care subsidies for low income families.

Signatures 88 to 131 of 168

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PETITION: We, the undersigned, want the State of Minnesota to continue to value the health and welfare of its children by providing adequate health care coverage and child-care subsidies for low income families.

Signatures 132 to 168 of 168

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FAIRVIEW
Fairview-University Medical Center

February 8, 2005

Hemophilia & Thrombosis Center
A collaboration with Children's Hospitals & Clinics - Minneapolis & St. Paul

420 Delaware Street SE, MMC 715
Minneapolis, MN 55455
Tel 612-626-6455
Fax 612-625-4955
1-800-688-5252 ext. 66455

RE: Senate File 65
House File 153

To Whom It May Concern:

The purpose of this communication is to clarify information about the current provision of comprehensive health care and supply of coagulation factor products to patients with hemophilia and other bleeding disorders in the State of Minnesota. We hope that this information will be taken into consideration in the wording and execution of the above-referenced Bill.

As you may be aware, Fairview-University Medical Center (F-UMC) and the Mayo Clinic are federally-funded Hemophilia Treatment Centers (HTC) within the state whose mandate it is to provide comprehensive health care to persons with bleeding disorders in Minnesota. In addition, the HTCs in Fargo, ND and Sioux Falls, SD provide care for some Minnesota residents who live closer to those cities. Currently however, only F-UMC and the Roger Maris Cancer Center in Fargo have 340B programs that purchase and dispense clotting factor concentrates under the Public Health Service (PHS) pricing system.

We are concerned that the wording of the Bill as currently written in SF 65 (section 45 ,lines 61.17 & 61.18) implies that all Minnesota residents receiving state financed health care will be required to receive their factor concentrates through F-UMC as the State's 'sole source provider'. We wish the State to note that federal law prohibits 340B HTCs from dispensing product at the PHS price + mark-up to any individual who is not a registered patient at that center. Thus, the patients with hemophilia who are receiving excellent care at one of the other three HTCs in our region will not be eligible to obtain product through a 340B HTC pharmacy at Fairview without transferring their care to F-UMC. Also the language of this Bill is not clear about the issue of whether Minnesota patients receiving care at the Fargo HTC, which does have a 340B program, would be able to obtain their clotting factor concentrate there.

Because of the chronic care needs of this patient population, the close relationship that is necessary with their care providers, and the difficulty that patients may have in traveling to our center, we believe that it would not be feasible to require all residents of the State of Minnesota to be seen by our center solely for the purpose of obtaining their medications.

We are committed to continuing dialogue regarding appropriate and cost effective treatment of this patient population and attempts to control health care costs. If you have questions or would like further information, please feel free to contact either Dr. Key or Beverly Christie at the numbers listed below.

Sincerely,

Nigel Key, MD
Medical Director
Hemophilia & Thrombosis Center
Phone 612-624-0123

Beverly Christie

Beverly Christie, RN
Program Manager
Phone 612-626-2722
Pager 612-899-6165

Minnesota Association of
COMMUNITY HEALTH CENTERS
www.mnachc.org

1113 E. Franklin Avenue, Suite 211 | Minneapolis, MN 55404 | 612.253.4715 | Fax 612.872.7849

Minnesota Association of Community Health Centers

Testimony

Health & Human Services Budget Division,
Senate Finance Committee
February 15, 2005
Governor's Budget Proposal 2006-2007

Madame Chair, committee members, my name is Rhonda Degelau. I am the Executive Director of the Minnesota Association of Community Health Centers. I'm here today to testify in opposition to the Governor's proposals to cut eligibility for MinnesotaCare.

The Governor's plan to cancel health insurance on 46,000 Minnesotans will bring tremendous personal hardship to many low-income workers in the state. It will also create a tremendous strain on the safety net of community clinics throughout the state, already hit hard by the budget cuts of 2003-2004, that care for the state's public programs patients and for the uninsured.

My organization represents 18 community clinics - located throughout Minnesota - that care for 129,000 patients, 39% of whom are uninsured and 37% of whom are enrolled in Medicaid or MinnesotaCare. The clinics provide medical, dental and mental health services to all, regardless of ability to pay.

Our community clinics already serve 50,000 uninsured patients. Thanks to the budget cuts of 2003-2004, we have seen our uninsured numbers grow by 10% in only two years. These clinics simply do not have the capacity or the funds to

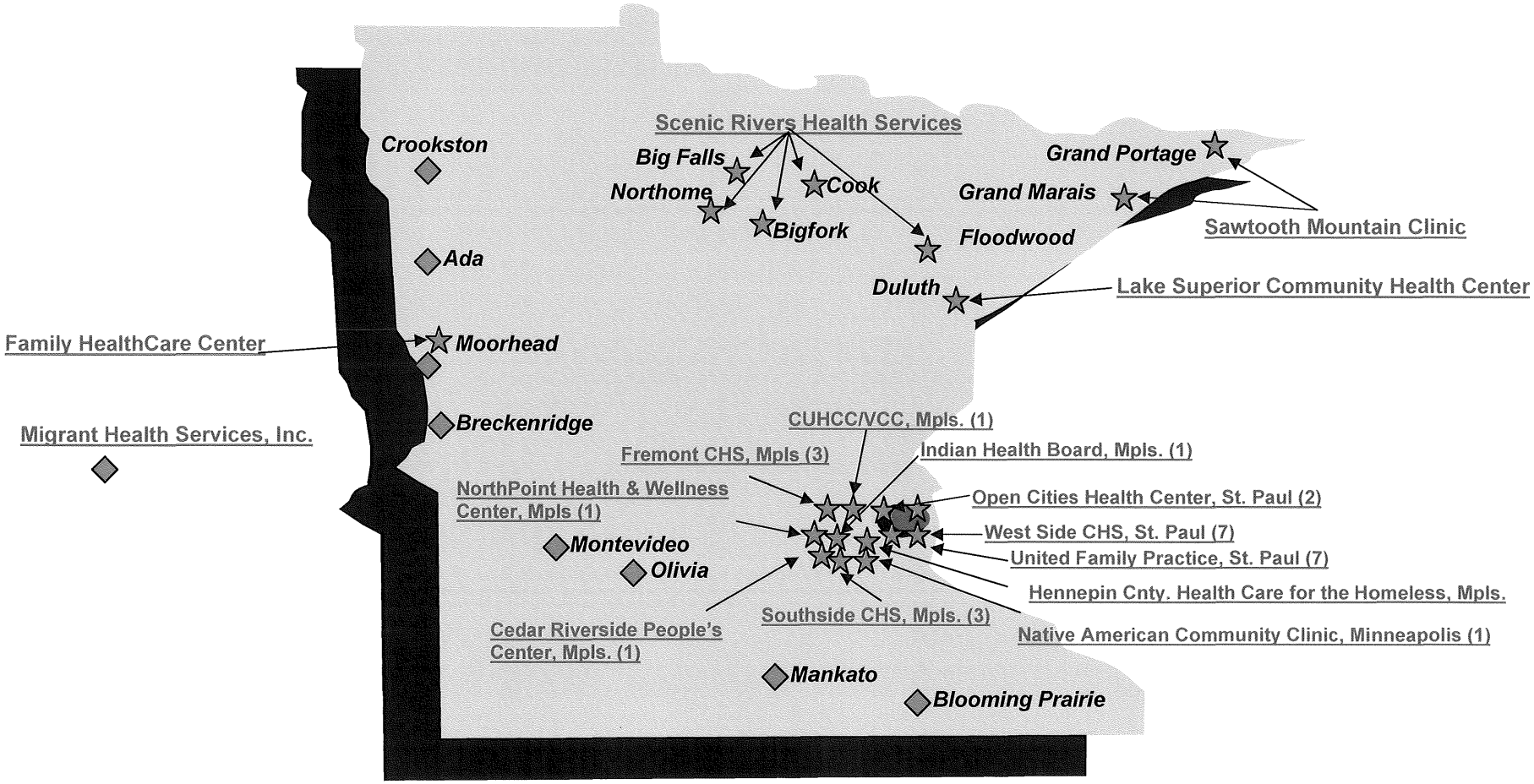
absorb the projected increases in uninsured that would seek care at these clinics if the Governor's proposals are enacted. At least half of those who would become uninsured under the Governor's plan live in the 12 counties served by our clinics.

I do not mean to suggest in any way that the newly uninsured are not welcome at our clinics. Of course they are welcome. It's the mission of each of these clinics to care for those most vulnerable. Many have been doing so for over 30 years. However, if this state continues to balance its budget by creating more uninsured year by year, we will reach a tipping point at which time clinic doors will be forced to close.

I urge the committee to consider revenue alternatives to the Governor's proposal - whether it be a tax, a surcharge, a fee - that would keep our public programs intact and would shore up the safety net. We can do better than this!

Minnesota Association of
COMMUNITY HEALTH CENTERS

Minnesota's Federally Qualified Health Centers



"Working Together for Affordable Health Care"

WORKING TOGETHER FOR AFFORDABLE HEALTH CARE

Minnesota Association of
COMMUNITY HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) and other providers that offer comprehensive preventive and primary health care services to all individuals, regardless of their ability to pay. Our member clinics provide medical, dental and mental health care to patients in urban, rural and tribal areas throughout the state. The majority of patients served by these clinics are low-income and uninsured.

HOW DO COMMUNITY HEALTH CENTERS BENEFIT MINNESOTA?

FQHCs help prevent illness and disease by supplying preventive and primary care for low-income individuals and families who might otherwise delay seeking medical attention. Not only do FQHCs reduce expensive emergency room visits, but FQHCs cost-effectively save both lives and dollars for Minnesota.

HOW ARE FQHCs FUNDED?

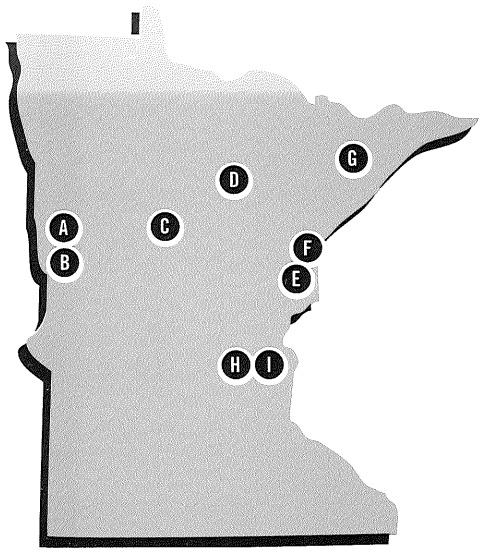
FQHCs are unique among health care providers in the fact that nearly 40 percent of their patients are uninsured. Uninsured and low-income patients contribute, as they are able, to their cost of care. Less than one-third of FQHC revenue can be attributed to federal funding sources.

WHY SUPPORT FQHCs?

The number of uninsured in Minnesota is on the rise. FQHCs provide a safety net for these individuals with sliding-scale fees, culturally competent care, translation and transportation services, and geographically convenient locations.

CLINICS OF THE MINNESOTA ASSOCIATION OF COMMUNITY HEALTH CENTERS

18 member organizations serving
129,000 patients annually at 54 sites.



A Migrant Health Services, Inc.
- Grafton
- Moorhead
- Seasonal locations

B Family Health Care Center
- Moorhead

C Leech Lake Tribal Health Services
- Ball Club
- Bemidji
- Cass Lake
- Inger

D Scenic Rivers Health Services
- Big Falls
- Bigfork
- Cook
- Floodwood
- Northome

E Fond du Lac Tribal Health Services
- Cloquet

F Lake Superior Health Center
- Duluth

G Sawtooth Mountain Clinic, Inc.
- Grand Marais

H MINNEAPOLIS
- Cedar Riverside People's Center
- Community University Health Care Center (CUHCC)
- Fremont Community Health Services, Inc.
- Hennepin County Health Care for the Homeless
- Indian Health Board of Minneapolis
- Native American Community Clinic
- NorthPoint Health and Wellness Center
- Southside Community Health Services, Inc.

I ST. PAUL
- Open Cities Health Center
- United Family Practice
- West Side Community Health Services, Inc.

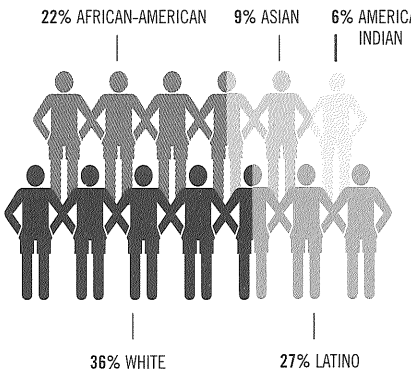
Minnesota Association of
COMMUNITY HEALTH CENTERS

E. Franklin Avenue, Suite 211 | Minneapolis, MN 55404 | Tel: 612.253.4715 | Fax: 612.872.7849 | info@mnachc.org | www.mnachc.org

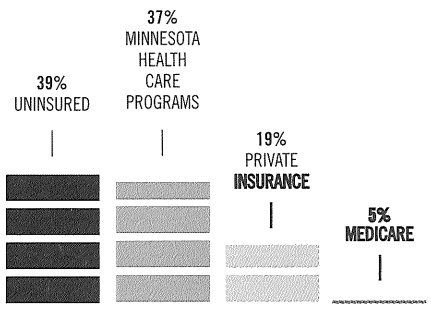
MINNESOTA'S COMMUNITY HEALTH CENTER PATIENT POPULATION

SERVING A RACIALLY DIVERSE POPULATION

COMMUNITY HEALTH CLINIC PATIENTS IN MINNESOTA



PATIENT INSURANCE STATUS AT MINNESOTA'S FQHCs

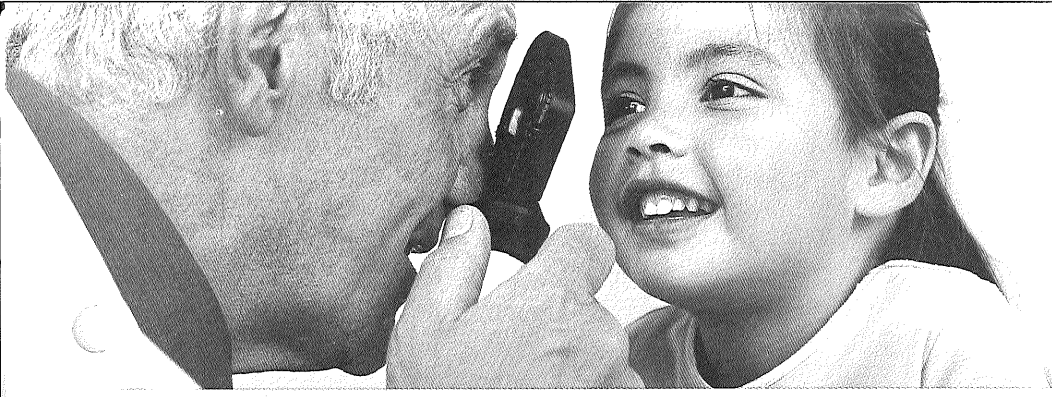


Visit www.mnachc.org for comprehensive data analysis.

TREATING UNINSURED, LOW-INCOME PATIENTS

- Minnesota's community health clinic patients are **FIVE TIMES MORE LIKELY TO BE BELOW 100% OF POVERTY** than the state's general population. (2003 Federal guidelines set poverty at annual income up to $18,400 for a family of four.)

- Compared to the state population, community health clinic patients are **EIGHT TIMES MORE LIKELY TO BE UNINSURED.** With a high percentage of uninsured patients, community health centers rely heavily on state, federal and private funds to remain in operation.



MNACHC SERVICES

A VOICE FOR COMMUNITY HEALTH CENTERS

MNACHC provides state and federal public policy analysis, educational programs and advocacy for member clinics. We advocate for policies that will maintain and increase access to community health care services for low-income and uninsured persons.

LEVERAGING FUNDS

At the state and federal levels, MNACHC fosters public and private partnerships to support health center infrastructure and opportunities for growth.

DATA CLEARINGHOUSE

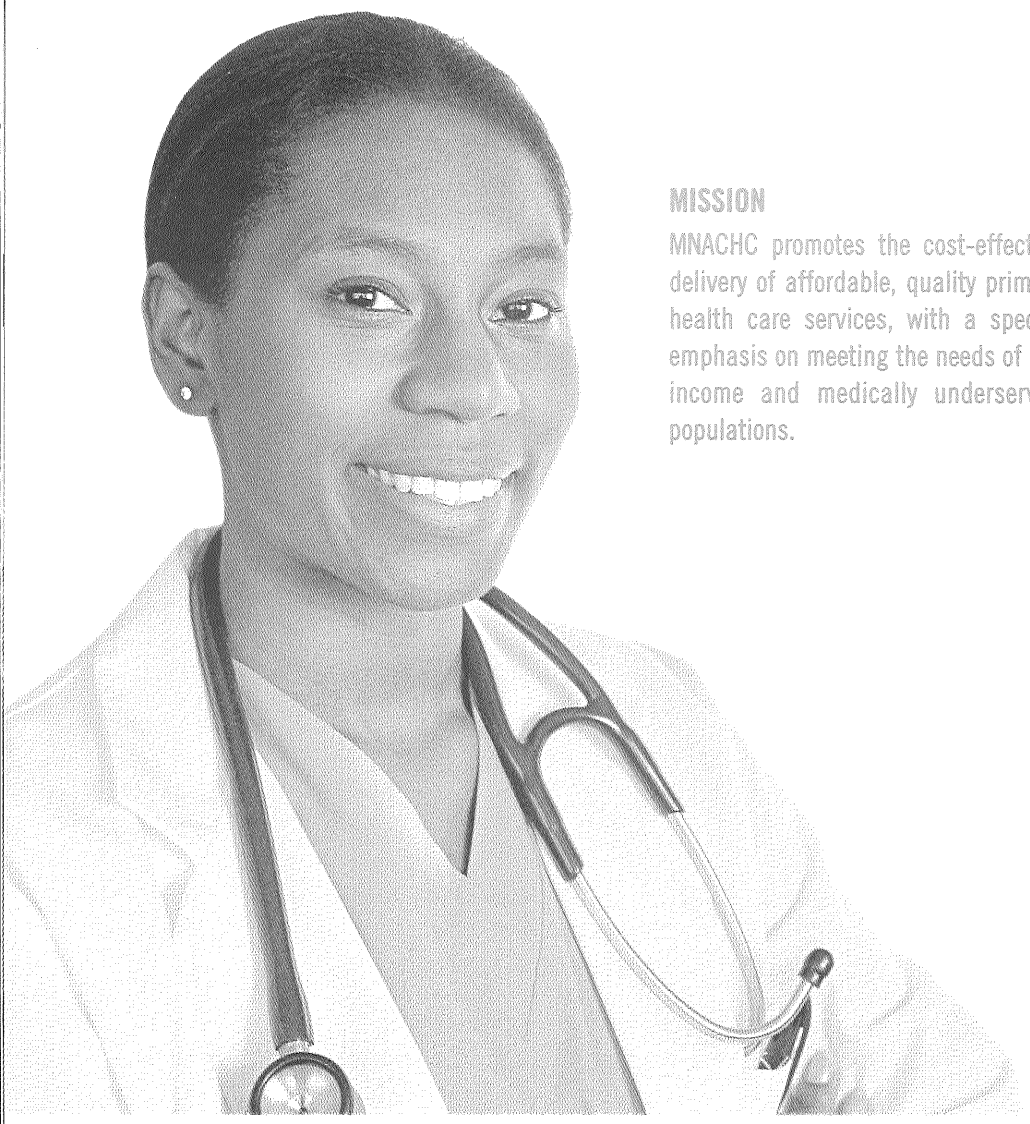
MNACHC compiles data on patient demographics, clinic revenue and market trends. Our Web site—www.mnachc.org—provides timely data and analysis for member clinics, government officials and the public at large.

COMMUNITY DEVELOPMENT

MNACHC identifies Minnesota communities that could benefit from FQHC presence and then assists these communities through the FQHC designation process. We also work to support the expansion of existing FQHCs throughout Minnesota.

TRAINING AND TECHNICAL ASSISTANCE

MNACHC equips community health centers with the administrative, financial and clinical tools necessary to sustain high-quality operations.



MISSION

MNACHC promotes the cost-effective delivery of affordable, quality primary health care services, with a special emphasis on meeting the needs of low income and medically underserved populations.

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Minnesota Association of
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Minnesota Association of
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MNACHC Fact Sheet

Fact Sheet 01, January 2005

An Introduction to Federally Qualified Health Centers

Federally Qualified Health Centers -- FQHCs, or simply "community health centers" -- are private, non-profit or public organizations that provide primary and preventive health care services to medically underserved populations.

Unlike other models of health care delivery, FQHCs focus not only on improving the health of individual patients, but improving the health status of the entire community.

There are several requirements that community health centers must meet before they qualify as an FQHC. Among these, community health centers must:

- ☑ Be located in a medically underserved area (MUA) or medically underserved population (MUP).
- ☑ Be incorporated as a non-profit entity or public organization
- ☑ Be governed by users of the health center - 51% of the Board of Directors are also patients at the health center
- ☑ Offer comprehensive preventive and primary health care for all age groups and life cycles including:
  - Health Services related to family medicine, internal medicine, pediatrics, obstetrics and gynecology;
  - Diagnostic Laboratory and Radiology Services;
  - Dental Services
  - Mental Health / Substance Abuse Services; and
  - Enabling Services such as transportation, outreach and language translation services.
- ☑ Accept all patients regardless of their ability to pay by offering a sliding fee scale to those at or below 200% of federal poverty guidelines.

A majority of Minnesota's FQHCs also participate in disease management collaboratives. The collaboratives focus on reducing health disparities for FQHC patients in the areas of cardiovascular health, diabetes and asthma.

Member Clinics

Cedar Riverside People's Center
Minneapolis

Community University Health Care Center,
Minneapolis

Family Health Care Center
Moorhead

Fond du Lac Tribal Health
Services, Cloquet

Fremont Community Health
Services, Minneapolis

Hennepin County Health Care for the
Homeless, Minneapolis

Indian Health Board of
Minneapolis

Leech Lake Tribal Health Services
Cass Lake

Lake Superior Community Health Center,
Duluth

Migrant Health Services, Inc.
Moorhead

Native American Community Clinic
Minneapolis

NorthPoint Health & Wellness Center
Minneapolis

Open Cities Health Center
Saint Paul

Sawtooth Mountain Clinic
Grand Marais

Scenic Rivers Health Services
Cook

Southside Community Health Services,
Minneapolis

United Family Practice
Saint Paul

West Side Community Health Services,
Saint Paul

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Health and Human Services Hearing
Tuesday, February 22, 2005
Brian Sperling—by Erin Sperling (Mom)

My name is Erin Sperling. I live in White Bear Lake, MN. I am a member of the Ramsey County Citizens Advisory Council on Developmental Disabilities, the White Bear Lake Parent Advisory Committee on Special Education, and Partners in Policymaking, Class 22. I also work and attend school full-time at the University of Minnesota. My husband, Brad, works from home, in order to help care for our 2 children: Sydney, age 9; and Brian, age 6, who was diagnosed with Autism Spectrum Disorder (ASD) in March 2003.

Our goals for Brian are the same as those goals we have for our daughter. We want Brian to become a happy, healthy, and productive member of society. To help him achieve these goals, Brian has received speech, occupational, music, and craniosacral therapies; attended preschool and swimming lessons; and he plays soccer and baseball. Medical Assistance (MA) helps defray the costs of co-pays and school therapy services, while also making it possible for us to hire Brian's Personal Care Attendant (PCA), who works hard to help Brian with issues related to behavior management, personal hygiene, and social development. Increases in the MA parental fees, however, have made it difficult for us to continue providing these opportunities for him.

Like many families, the majority of our decisions are dictated by our finances. We elected health insurance from the lowest cost provider, for example, so our out-of-pocket expenses for health insurance are currently just $73 per month. Our medical choices are rather restricted as a result of our decision, however. In addition, a number of services Brian receives are not covered by health insurance. Each monthly craniosacral therapy session is $80, while each weekly music therapy session is $45. One appointment with a homeopathic physician cost us $500. While these amounts may not seem like much, they do add up.

MA initially provided us with an incredibly cost-effective way to fund some services. With a 2002 adjusted gross income of $32,486. In 2003, my husband dissolved his home business, and our adjusted gross income increased to just over $68,000—a primarily artificial increase. Because of this increase, our monthly fee increased by almost $400. While I would like to emphasize that *we are willing to pay our fair share of fees for services to keep our son in the community*, any further increases will price MA out of our financial reach, leaving us with little choice but to either pay for all services out-of-pocket or discontinue many of the very services which have benefited our son.

When Brian was first diagnosed, I spoke with a number of parents and professionals about the options available for providing Brian with services. The Community Alternatives for Disabled Individuals (CADI) and the Mental Retardation and Related Conditions (MR/RC) waivers, were specifically mentioned as flexible, cost-effective resources that we could utilize in order to provide needed therapies and other services for Brian. I found out, however, that these waivers were essentially frozen to new enrollment. We have been on the waitlist for the MR/RC waiver since Brian was diagnosed in 2003, and we just got on the waitlist for the CADI waiver earlier this

month. If the number of available slots for the CADI is limited to 95 per month, while the MR/RC waiver is restricted to 50 emergency slots over two years, it seems all but certain that Brian, and many others like him, will be waiting a very, very long time for waivered funding which, according to David Osborne and Peter Hutchinson's book, "The Price of Government: Getting the Results We Need in an Age of Permanent Fiscal Crisis", "greatly improves customer satisfaction at less cost (p. 15)."

As Minnesota now faces a projected deficit of $1.4 billion, including inflation, I ask you, the state, to please consider individuals like my son as you make the difficult decisions that lie ahead of you. Keeping individuals in the community now may cost more money up front, but this proactive investment is much better for everyone than the reactive policies that will need to be put in place to work with individuals with disabilities later on. Thank you

February 18, 2005

Senator Linda Berglin
309 State Capital
St. Paul, MN. 55155

Re: Governor Pawlenty's Proposed Budget Cuts to Minnesota Care

Dear Senator Berglin:
I am writing to express my concern for the possible budget cuts proposed per Governor Pawlenty. Please add my letter to the file for public testimony scheduled for February 22nd and 23rd, 2005. Thank you for your hard work and willingness to assist your constituents in the community regarding this important matter.

I am a single 45 year old female who does not have dependents. I have been enrolled in the program as of August 2004 to the present date. I faithfully pay my monthly premiums and copays. The coverage I have is Medica Minnesota Care- Basic+1. I have also been enrolled in Minnesota Care in the past and find the health care provider coverage a decent and reliable way of treatment of my health care needs.

I have been employed for one year with a temporary employment agency. My rate of pay is $10.00 - $11.00 hourly. I can not afford the health insurance benefits offered through my employer.

I was recently diagnosed with an illness that requires surgery. This has become a chronic condition that has developed over time into a potentially serious condition. This condition could have been treated previously and not have developed to the point of requiring surgery. I share this because I lost my job lost my job last February and my COBRA coverage terminated on December 2003. There is a four month waiting period for Minnesota Care if one has previous health insurance coverage. That meant I had a gap or lapse of health insurance coverage. I could not afford to pay for M.D. visits and I did not want to be responsible for a large debt that I could not pay to a health care provider (s). I had no other choice but to risk lack of treatment and care of a doctor.

It is my concern that myself and others should not have to be put in these situations of having to choose between paying for rent or paying for health insurance coverage. It is simply unconscionable. Governor Pawlenty is incorrect to state "this is a welfare driven program". He seems to view individuals such as myself as "looking for a free ride" from the state of Minnesota. He does not seem to understand or empathize with individuals of lower income brackets who can't afford out of pocket health care costs.

I understand his need to balance a budget but it would seem a more humane approach would benefit myself and others who would be harmed by a decision to terminate health care coverage. Minnesota Care was developed in1992 for the express purpose of helping those individuals in the community that could NOT afford to help themselves. It was created to give coverage to those who desperately needed this type of program. Individuals who for whatever reason must choose between food, rent or health care costs.

I honestly believe that the Governor's proposal would harm individuals including the children and the elderly who already live in poverty by denying the coverage they need to stay healthy and productive. How can we deny the obvious fact the many individuals are lacking proper health care coverage and do not have access any type of medical care.

My perspective is that of many individuals who will be greatly affected by this matter if it becomes a reality. If I am terminated from Minnesota Care I will risk further decline of my health and not have access to proper health care treatment. I need an eye exam and a new prescription but I can't afford the $25.00 copay with Minnesota Care now. How can I afford this without health care coverage? I know $25.00 does not seem like much but I have to pay for the cost from a limited income. I need bifocals so the cost is more than the $25.00 copay.

I do wish to improve my educational experience so I can become more self-sufficient. Then I would be able to afford to health insurance provided per an employer. Currently I must depend upon Minnesota Care for that safety net. Please don't take that away from me!

I urge the Governor and the legislature to seriously consider everyone who will be affected by budget cuts affecting the Minnesota Care program. I urge this panel to seek a solution to this proposal and to find an alternative that meets the needs of myself and others enrolled in this program. Minnesota Care is a solid program that serves the needs of the community. I wonder what would happen to Minnesota Care if the Governor or his family had to depend upon this type of health care coverage.

Thank you for letting me share my perspective with this committee.

Respectfully submitted,

Kimberly A. Howard

Kimberly A. Howard
171 North McKnight Road
Apt 209
St. Paul, MN. 55119
651-731-7784

Greater Minnesota Health Care Coalition
GMHCC
47 N. Park St.
Mora, Minnesota 55051
Toll-free: 1-888-694-5055

DULUTH
*
ST. CLOUD
*
ROCHESTER
*
MORA

February 22, 2005

Testimony of Dave Ulstrom, Greater Minnesota Health Care Coalition,
To the Minnesota Senate Health & Human Services Budget Division

My name is Dave Ulstrom, and I'm speaking on behalf of the Greater Minnesota Health Care Coalition, or GMHCC for short. GMHCC is a grassroots citizen organization with several thousand members, and we have extensive experience in health care legislation. We proposed the legislation which became the Fair Drug Pricing Act, and we were invited one year ago by the Senate Health & Family Security Committee to help explain the new Medicare law.

I live Mora, and I'm retired. I served as a Kanabec County Commissioner for eight years between 1990 and 2002, so I have direct experience with Kanabec County's operation of Medical Assistance and GAMC.

GMHCC believes that last year's cuts, and the current proposed ones, for Medical Assistance, MinnesotaCare and GAMC benefits and eligibility are very hurtful to the citizens of this state. Cuts should be avoided if at all possible. Yet we also realize that the state faces severe budget deficits.

We are here to say that the state can obtain more money to go towards the benefits of these programs without raising taxes. How? By eliminating a certain kind of waste that is currently in the operation of these programs. That waste is excessive administrative expense, and it stems from having private sector managed care companies administer these programs.

We all know that the legislature decided to use privatized administration in the hope that it would save taxpayer dollars for these programs. Unfortunately, this has not happened.

I have some proof of how you can get lower administrative cost by removing the managed care companies. Kanabec County, plus eight other counties, formed a County-Based Program for our MA and GAMC programs. These had been operated under the PMAP system with managed care companies. In 2001, our nine counties began operating the programs ourselves, through our South Country Health Alliance, using direct contracting with providers. Here is what our results have been:

In 2003 the South Country Health Alliance took in $46,649,674 in premium revenue. The administrative expense was $3,718,816, which is 7.97 % of revenue. We also generated a net revenue surplus of $5,731,386, which is 12.2 %. These figures are posted right on the Department of Health's website, at: www.health.state.mn.us/divs/hpsc/mcs/financial.htm. And by the way, the administrative expense of the IM Care plan in Grand Rapids was even better than ours: 6.95 %.

How does our administrative expense of 7.97 % compare to the managed care companies? The best figure is probably the one that Attorney General Mike Hatch found when he audited Medica's books. He discovered an administrative expense in 2000 of 18.7 %, even though Medica had reported to the state only 12.7 %. We think that the higher number that Hatch found is probably closer to the truth, and that the managed care companies are under-reporting their true administrative expense to the state. We believe that they are still under-reporting their administrative cost. If you doubt this, then you should require more audits of the kind done by the Attorney General.

If you compare Medica's 18.7 percent to the South Country Health Alliance's 7.97 percent, you have a difference of 10.7 percent.

What does this mean to the state legislature? It means a potential savings of over 10 percent off the cost of MinnesotaCare, GAMC, and roughly one-third of Medical Assistance, which is the portion of MA run by managed care companies. For fiscal year 2004, the total cost of MinnCare is about $487 million and $245 million for GMAC. One-third of MA's cost is about $1.62 billion, with about half of that paid by the state. Therefore, savings of 10 percent would be about $48 million for MinnCare, $24 million for GMAC, and $80 million in state money for Medical Assistance. That's a grand total of over $150 million a year, Senators. This is of course just a ballpark figure, but it shows there is a strong likelihood that you can save an enormous amount of money for these programs, and use it to prevent benefit cuts.

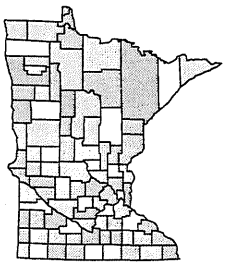
The way to capture these savings is for the legislature to return the administration of these programs back to the counties or DHS with direct contracting. Twenty-three (23) counties are already using direct contracting.

All Minnesota counties could potentially do pre-paid direct contracting like the South Country Health Alliance, except for three: Hennepin, Ramsey, and St. Louis. Those are the counties, of course, where the biggest amount of administrative savings could be captured. However, they are prohibited by federal rules from doing pre-paid direct contracting with selected providers, although we don't understand why they couldn't be allowed to do direct contracting on a non-exclusionary basis. For these three counties, perhaps the only way to remove the managed care company involvement is to have a fee for service payment system with all providers. The same could be done with any other counties that did not choose to be part of a pre-paid direct contracting plan.

The bottom line is that the insurance companies just can't administer health care more cheaply than the government. In fact, it's just the opposite.

Thank you.

Dave Ulstrom
Mora, MN
(320) 679-4049



HealthLinks

The official publication of the **GMHCC**
Greater Minnesota Health Care Coalition

Duluth - St. Cloud - Rochester - Mora

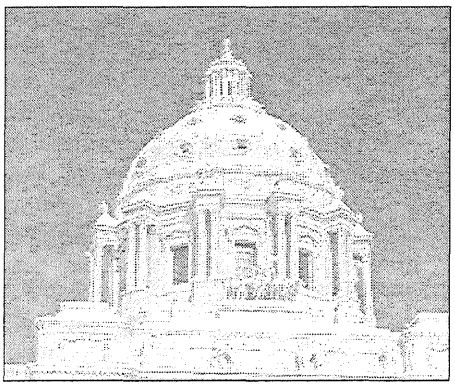
February 2005

What will the 2005 Minnesota legislature do about health care?

It's a good question, that nobody really knows the answer to. There are important reforms that groups like Greater MN Health Care Coalition (GMHCC) want to tackle, but there is also "unfinished business" to deal with the changes that the legislature has made recently, and especially in the last session. Let's look at those first:

On the radar screen

A high priority for many legislators is to deal with the cutbacks that were made in MinnesotaCare, the state's health care system for many low income (mostly working) families. Deep cuts were made last year to help reduce the state's



huge budget deficit. One of the changes was to place a $5,000 yearly limit on care. This has proven to be a disaster for people with high-cost chronic diseases like diabetes, whose usual care for their conditions greatly exceeds the limit.

Adding insult to injury, the legislature also decided to take the Health Care Provider tax, which was created in order to fund MinnCare, and put it directly into the General Fund -- instead of keeping it dedicated for MinnCare program expenses.

The Medicaid program (called Medical Assistance in Minnesota) has also suffered cuts, and is in danger of being cut even more as Congress contemplates reducing its portion of Medicaid funding.

Good ideas - if we can get common sense to prevail

Meanwhile, groups such as GMHCC have proposals that would save health care dollars, including those that are paid by the taxpayers. Examples of these ideas are: Making the transition to a public health insurance system, that would save enormous amounts of money for everyone; Using prescription drug imports that cost much less money; Eliminating the waste of administrative dollars that results from having insurance companies run the state's health care programs; and Limiting the expensive waste of duplicated, unnecessary equipment and surgical facilities. Good ideas such as these face the danger of being "drowned out" in the legislature's scramble to deal with its immediate health care funding crises.

Don't hold your breath

Unfortunately, whether the legislature makes any progress on health care depends a lot on the degree to which lawmakers get preoccupied with other pressing issues. One of these is approving the bonding projects that should have been agreed upon this last session but weren't. Another is revisiting the system of revenues from fees and taxes. The famous "no new taxes" pledge by Governor Pawlenty and many legislators will have to be reconsidered. It will have to be acknowledged that the pledge has already been broken, in terms of state fees that were raised, and by shifting of expense to the local level, which resulted in raising many people's property taxes.

GMHCC will be offering testimony at the Senate Health & Human Services Budget Committee hearings on Tuesday, February 22 between 9 and 11:30 a.m.

Four "Seniors" Groups Campaigned for Pro-PhRMA Candidates

With its eyes on passage of an industry-friendly Medicare prescription drug bill, the Pharmaceutical Research and Manufacturers of America (PhRMA) appears to have quietly channeled as much as $41 million to four stealth PACs in 2002 to help elect a Congress sympathetic to the pharmaceutical industry's interests, according to a new Public Citizen report.

Money that likely came from PhRMA, the drug industry's trade association, enabled the United Seniors Association, 60 Plus Association, the Seniors Coalition and America 21 to broadcast ads and send direct mail in 39 U.S. Senate and House contests that year, supporting candidates friendly to PhRMA's agenda and criticizing those who weren't, the report reveals.

At least one of the groups, United Seniors Association (USA), was again active in the 2004 elections, recently sponsoring TV ads in 17 or more House races that praise incumbents who supported the PhRMA-backed Medicare drug law pushed by President Bush and passed by Congress in 2003.

Released in September, *Big PhRMA's Stealth PACs: How the Drug Industry Uses 501© Non-profit Groups to Influence Elections* report is available at www.stealthpacs.org, a new Public Citizen Web site and comprehensive database to track 501© non-profit groups active in elections, which Public Citizen has dubbed the "new stealth PACs."

"The Medicare drug bill is a gold mine for the pharmaceutical companies because it expands their base of paying customers for brand-name drugs and protects them from lower-cost foreign imports and government attempts to negotiate price discounts," said Frank Clemente, director of Public Citizen's Congress Watch. "PhRMA's apparent bankrolling of these stealth PACs left voters with no way of knowing whether the campaign messages aimed at them were bought with the drug industry's money or whether PhRMA helped elect a Congress that will do its bidding and enact industry-friendly bills like the Medicare drug law."

The four groups PhRMA apparently financed are registered within Section 501c(4) of the tax code as social welfare organizations. These and other politically active groups also registered under Sections 501c(5) and 501c(6) of the tax code are allowed to accept unlimited amounts of money from any donor without ever having to publicly divulge the source of the funds, according to Public Citizen.

Groups with these three tax statuses are permitted to make substantial political expenditures, which the IRS defines as expenditures intended to influence the outcomes of elections, but they are prohibited from making electoral activities their *primary* purpose.

The group Public Citizen asked the agency to "consider initiating a formal investigation into the financial transactions and electioneering activities" of the four groups that appear to have been funded by PhRMA. Public Citizen believes that in 2002, the PhRMA stealth PACs may have engaged in enough activities intended to influence elections to raise the question of whether they violated the prohibition against allowing political work to be their *primary* activity.

Further, each of the four PhRMA stealth PACs declared zero political expenditures to the IRS, claims that do not seem plausible given the content of the groups' television commercials and direct mailings, the timing of their messages, and the groups' decisions to direct the messages disproportionately to voters who lived in politically competitive states and congressional districts.

Additionally, PhRMA failed to disclose its grants to USA and 60 Plus, to which it is known to have given money in 2002. And if PhRMA is the source of the other large contributions to the Seniors Coalition and America 21 identified in the Public Citizen report, it again failed to disclose these grants.

(from Public Citizen)

Getting his (un)just reward?

Former Congressman Billy Tauzin (R-Louisiana) was named the new president and CEO of the Pharmaceutical Research and Manufacturers Association of America (PhRMA) on Dec. 15.

He was a lead negotiator for the huge Medicare revisions that were enacted a year ago, and was – surprise, surprise -- offered the PhRMA job just two months after enactment of the bill. His new job pays $2 million a year, which is a tiny fraction of the increase in profits that the drug companies will get thanks to Rep. Tauzin having done their bidding.

Rep. Nancy Pelosi summed it up quite accurately: He "secured billions of taxpayer money for the drug companies. Now, Mr. Tauzin will be getting millions from drug companies in payback. The appearance is unseemly, undignified and unethical."

Social Security Overhaul Proposals Being Offered

News sources around the country r reporting that the ad campaign for pi moting Social Security changes is in excess of $50 million dollars. The focus of the ads will be the current proposals from the White House to change Social Security through what is called "privatization."

Although there is no clear cut plan at this point, the ad campaign is designed to spur debate among people and nudge them towards moving Social Security dollars out of the traditional government run system.

Under the most often proposed scenario, these diverted dollars would then be placed into private accounts (stocks). There would be no guarantee of any return on these dollars, but advocates for this plan say that it's "likely" that people will end up with more retirement income under this method.

There are at least two sides to t debate. On one side, you have the cu rent administration, under the lead of President Bush, saying that there is an "imminent crisis" and that the Social Security system is "flat bust" (the President's term). They report that the current system is broke and that future retirees will likely see a disappearing ability for the program to pay full benefits after 2018.

On the other side, you have other members of Congress, including a number of Republicans, that say the system isn't broke but that it does require a few common sense adjustments. Supporting their arguments against radical change are economic projections that show that the existing system can pay full benefits until the year 2042, and perhaps longer. They also worry that putting retirement dollars into the stock market is always a risky proposition.

With an issue this large there are also dozens of other complications and unknowns. One of the biggest items to be considered is the group of disabled people current receiving Social Security benefits. The question of how these changes will affect them is subject to much debate.

Social Security disability benefits may not be safe from the across-the-

board cuts that are likely in President Bush's proposal to allow personal investment accounts.

Retirement and disability benefits are calculated using the same formula, so if future promised retirement benefits are cut, then disability benefits also would be reduced _ unless the program is somehow separated.

That also raises big questions about how investment accounts would be structured for disabled people, especially if they get injured at a young age or are dependent on a parent. Disabled beneficiaries typically work less and need benefits sooner, so the accounts would not provide enough income to these people.

Currently, disabled workers move through the Social Security system, often unaware they draw their benefits from the disability program until they reach retirement age and shift to the retirement program. That would change with investment accounts, advocates claim, with people falling through holes in a new system.

About 16 percent of the 47 million people receiving Social Security benefits are disabled workers and their dependents. The impact of accounts on beneficiaries who aren't retirees hasn't been publicly discussed yet by the Bush administration.

What is Social Security *Privatization...*

Q. Exactly what is meant by the term "privatization?"

A. "Privatization" is often used as a synonym for the idea of taking some of the money workers currently pay into the Social Security system and diverting it into individually owned accounts, where each worker would bear some risk for how his or her investments performed. These accounts would be "carved-out" of Social Security.

Diverting money away from Social Security and into individual accounts can be risky. It involves trading some of today's inflation protected, lifetime guaranteed benefit for an account subject to market risk and not guaranteed to last a lifetime or keep pace with inflation. Inflation, market turns or loss of employment can mean that your private account may not have enough money to provide an adequate benefit.

There is a lot of debate on the semantics rather than the substance. It doesn't matter if you call the concept "privatization," "personalization," or anything else, diverting Social Security revenues into individual accounts shifts risk to the individual and weakens the financial status of Social Security itself.

Q. Many elected officials say they want to protect Social Security. Do they all have the same position?

A. The debate over Social Security reform can certainly be confusing. While just about every elected official says he or she wants to "strengthen Social Security," ideas about how to do that can be very different. Some plans to strengthen Social Security would actually jeopardize the program's guarantees.

Q. Is Social Security in financial trouble?

A. It depends on who you listen who and how they do their calculations. Social Security is projected to have enough assets to pay 100% of benefits until 2042. After that, incoming revenues will be enough to pay more than 75% of benefits for decades to come. Some changes are needed and doing this mean some hard choices.

Q. Wouldn't these accounts give me control over my own money?

A. Personal control can be appealing. In reality, investment choices would likely be limited, at least initially. For example the President's Commission to Strengthen Social Security, which proposed carve-out accounts, structured them so that workers had just a handful of investment options. This was done to keep the administrative costs down.

Q. Does this mean I shouldn't invest money for retirement in the stock market?

A. Social Security was never intended to be your only source of retirement income, just a safe, reliable piece of a smart retirement plan. Ideally, you should build on Social Security's base with a pension, an IRA, a 401(k) or other investments. When added to Social Security, these kinds of private investments provide a more adequate retirement income.

Q. How do carve-out accounts affect Social Security's finances?

A. Diverting money out of Social Security into individual accounts weakens Social Security's long-term financial health. Since current payroll taxes are used to pay benefits to beneficiaries, transferring money into individual accounts means that less money will be available to pay promised benefits. In order to avoid major benefit cuts, younger workers would have to pay twice—once to fund the new account and again to meet Social Security's current obligations.

Q. What will Congress say about Social Security change?

A. It's not important whether you call individual accounts carved-out of Social Security "private accounts," personalization, or anything else. What really matters is the impact. You should ask the officials in-depth questions about exactly *how* they want to strengthen Social Security. It's always smart to be a bit skeptical if they offer ideas that sound too good to be true.

Medicare and Social Security are being threatened under the guise of Improvement.

Dave Durenberger

"The focus should be on the financial condition of Medicare not on Social Security. Of the two issues, Medicare is in need of more immediate attention..."

Beware the "Seniors Coalition"

from: GMHCC Editorial Board

You can't turn on the radio nowadays without hearing the most recent propaganda from a group that calls itself the "Seniors Coalition." Who are they and what are they all about? They are a group of front people and lobbyists for the U.S. pharmaceutical industry, some of them former (perhaps current?) employees of drug companies. This group has a message of fear that it hopes to spread to seniors, and all Americans, about the use of prescription drugs obtained outside of the United States. They want to even suggest that if you order prescription medications outside of the U.S. your actions are akin to aiding and abetting terrorists. Another idea they hope to promote is the lack of safety with these prescriptions. That's not true and it's certainly manipulative on their part.

These lies and half truths are designed to thwart efforts by many groups to get fair treatment and fair drug prices in the United States as compared to the rest of the world. A recent U.S. Supreme Court ruling in Maine stated that a law that passed there two years ago was indeed constitutional and can be put into place to lower prescription prices. This is good news for all those states waiting in the wings to enact similar bills.

Minnesota passed a weak version of that (Maine) bill in 2003. It's weak because it has restrictive income guidelines. The other weak part of the Minnesota legislation (Fair Drug Pricing Act) is that it isn't targeted to start until June of 2005, or later.

Minnesota's legislators used the budget deficit as an excuse for not starting the program immediately, but the truth of the matter is that the program is self funded and would repay any startup costs within 24 months. There would be no tax funding needed because the program sustains itself by using a small portion of the rebates required from drug companies. This watered down version of the bill offers *some* relief to seniors, but what about everyone else?

There is also one other significant drawback to the plans that have been passed under Medicare. The Medicare bill includes provisions that force or coerce people into HMO's for their health care needs in order to also get some prescription drug price assistance. So how many HMO's are serving your rural township at this time? We don't see any around this part of the state or most other rural communities in Minnesota. What happens to those folks?

Back to this whole matter related to the claims of the "Seniors Coalition" out of Washington, D.C. We agree that there is danger in buying prescriptions outside of the United States. The danger is that pharmaceutical companies feel threatened by the revenue loss and will spend more than $35,000,000 (thirty-five million dollars) over the next year (before the next elections) lobbying your local and national elected officials or buying more radio and television ads to scare people away from thinking about how high their drug prices are.

Wouldn't this money be better spent in simply lowering prescription drug prices to consumers?

There's also some very important numbers to keep in mind: 1.) The drug industry spends twice as much* for marketing and administration as it does for research and development. 2.) Prescription drug sales totaled in excess of $100 billion* for the first time in 1999. 3.) Drug companies spent $13.6 billion* in 1999 promoting their products to the medical profession. 4.) They spent over $1.1 billion* on advertising their prescription drug products on television, and spent a total of $1.8 billion* promoting their products to the consumer. 5.) The industry spent over $75 million* in 2001 lobbying Congress. These are staggering numbers.

We agree with the original idea of the recent radio commercials: There terrorist actions, as the "Seniors Coalition" suggests... it's the drug companies and their front groups spreading lies and distorting the truth. If you don't want to aid terrorists, simply turn off the radio or change the channel next time you hear: "Here's a message from the Senior's Coalition..."

- GMHCC Editorial Board -

*(IMS Health Industry Report 2002)

This is how you can help...

You can help fix the Health Care system in Minnesota (as well as America) by joining the **Greater Minnesota Health Care Coalition** effort. *Here's how you can help:*

[ ] Attend "action" meetings in your area
[ ] Become a member of the GMHCC ($12.00 per year)
[ ] Make a tax-deductible donation to the GMHCC
[ ] ***I will*** _____

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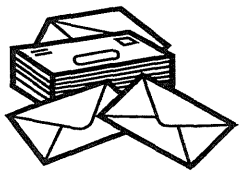

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TO: **Members of the Senate Health and Human Services Budget Division**

FROM: **Anne L. Henry**

RE: **Governor's Proposed 2006-2007 Budget for Human Services**

DATE: **February 15, 2005**

Our office represents persons with significant disabilities and their families across Minnesota. We have some serious concerns about the Governor's proposed budget, both because of some of the proposals and because a number of other issues are not dealt with in the budget proposal.

GOVERNOR'S BUDGET

1. Home and Community-Based Services Caseload Growth Limits, page 41.

The Governor proposes to continue to limit access to home and community-based services which are an alternative to nursing facility, neurobehavioral hospital and ICF/MR institutional care.

The three waiver programs, CADI (an alternative to nursing facility care), TBI (an alternative to either nursing facility or neurobehavioral hospital levels of care) and the MR/RC (alternative to ICF/MR) level of care have been tightly controlled during the current biennium, resulting in waiting lists and disrupted lives for thousands of Minnesotans affected by significant disability.

When examining the proposed caseload growth limits in the Governor's budget, it is important to remember that the savings reflect only the state portion of funding for services cut for the coming biennium. The home and community-based waiver services are funded under the Medicaid program, which means the federal government matches dollar for dollar state funding. Over 4,500 persons with disabilities qualifying for an institutional level of care will not have access to waiver services under the Governor's proposal and over $103 million in services will be lost. Persons with disabilities use waiver services in order to improve their functioning and increase their independence in the community. We urge that you fund the home and community-based waiver programs at the level of need in the November 2004 forecast and not adopt the Governor's proposed cuts.

2. **Elimination of MinnesotaCare for Adults Without Children, page 29.**

The Governor's proposal to eliminate MinnesotaCare for adults without children and leave as a safety net the General Assistance Medical Care (GAMC) program with an income limit of $582 per month will cause significant hardship for many Minnesotans with chronic illnesses and disabilities. A number of individuals with chronic and disabling conditions use MinnesotaCare to obtain treatment in order to remain as functional as possible to continue employment. Without access to needed health care, many individuals will be forced to spend income needed for housing on health care in order to qualify for GAMC. Rent or mortgage payments will not be made and lives will spiral downward to total dependence. This proposal impoverishes yet another group of Minnesotans with chronic illnesses and disabling conditions because of their health care needs. We urge that MinnesotaCare for adults without children not be eliminated.

3. **Improvements in Mental Health Coverage, page 45.**

We support the Governor's recommended improvements in mental health coverage. Treatment Foster Care and Assertive Community Treatment Services are positive additions for children and adolescents. Use of consultation and interactive video to improve access to psychiatric care are welcome additions to the MA, GAMC and MNCARE programs.

4. **Add Staff for DHS Licensing and Background Studies, page 8.**

We support a strong licensing and background study effort at DHS. Vulnerable adults and children must have oversight to reduce exploitation, abuse and neglect. We support the Governor's proposal for increased staff for this purpose.

Issues Not Addressed in the Governor's Budget

1. **$500 Cap on Dental Care for Adults on Medical Assistance and General Assistance Medical Care.**

The $500 cap on dental care applied to adults with disabilities is a very serious barrier to appropriate dental services and has worsened Minnesota's significant dental access problems. More and more individuals with disabilities are appearing in Urgent Care and Emergency Rooms with dental pain because they cannot be seen by dentists given the $500 limit. Persons with disabilities have significant needs for regular dental care due to their health conditions, including side effects from numerous medications, such as anti-seizure and anti-psychotic drugs. Infection and loss of function will only increase health care costs and reduce the ability of persons with disabilities to function. We urge that you remove the $500 service cap for dental care for adults using Medical Assistance and General Assistance Medical Care.

2. **Co-Payments.**

The co-payments for adults with disabilities using Medical Assistance General Care (GAMC) have had several negative impacts, including reducing assess to needed health care and medicine. We urge that the co-payments for Medical Assistance and General Assistance Medical Care adopted in 2003 be removed.

3. **Medicare Part D Drug Benefits for Dual Eligible.**

We are very concerned about the impact of Medicare Part D on persons who also are eligible for Minnesota's Medical Assistance program. We believe it is very likely our state will need to provide **more** than information and enrollment assistance to MA recipients who must turn to Medicare Part D for their prescriptions. **One significant problem will be the loss of the $20 out-of-pocket co-payment limit for prescriptions for the dual eligibles not living in facilities.** The out-of-pocket costs are going to be a serious hardship to those with very complex medical conditions requiring a lot of medications.

4. **Restore MFIP-SSI Cut.**

We support restoring $125 per month for MFIP families with a member with disabilities receiving SSI.

5. **Reduce Steep Parent Fees**

The steep increase in parent fees enacted in 2003 is creating a hardship for many families. We urge that parent fees be reduced.

6. **Service Provider Rate Increase Needed.**

We support a rate increase for service providers to retain and attract staff needed to provide services for children and adults with disabilities.

7. **Restore Social Services Funding for Counties.**

The 2003 cuts to County social services funding has hurt persons with disabilities. Access to children's mental health services, employment programs and day training and habilitation services for adults has been reduced. The cut in social services funding combined with cost shifts to counties such as the 10 percent payment for large ICF/MR's have resulted in serious cuts to services for persons with disabilities at the county level. The $50 million cut in projects of regional significance, page 18, is funding which should be restored to counties for social services.

Thank you for your consideration of the needs of persons with disabilities when deliberating on the health and human services budget.

ALH:nb

LISA BERGREN SALINAS'S LETTER, Child with Disabilities on Waiting List for Waiver Services

Members of the committee:
Unfortunately, I can not be here today to give you my testimony in person as I have done in the past. I am at home with my son and have not left home in a month as my son is in need of 24 hour nursing care. My son Erik is 11 years old and is physically impaired, he has Cerebral Palsy (CP). He is at home because he had a spinal fusion for Scoliosis due to his CP. Erik has had many complex medical needs since he was diagnosed as having CP as a new born, resulting in several surgeries over his short life. (Over 50).

Erik's funding is through the Consumer Support Grant (CSG). Two years ago Erik had complications that resulted in gangrene in both feet, a severe 3 degree burn in his functional arm and Meningitis. With the help of his CSG we were able to have the nursing care we needed in our home by paying nurses that we knew would help us out. We never had to ask for help from social workers, hospital staff, or doctors. We cared for him at home during this whole time until recovery.

So, what is so different this time? We knew last spring that the exception part of CSG was eliminated and that we had a big surgery coming. We are also paying four times more in our parental fees due to funding cuts. We knew that financially we were in trouble. With the grant cut to such a small amount we knew that we would not be able to take care of our son at home. This lack of funding resulted in a longer hospital stay with this surgery as we could not care for him at home. We did do everything we could to change this from happening to our son. We asked to have his funding changed to a CAC or CADI waiver in March. (He has always met these requirements but we could do a better job with the flexibility of CSG even so he had less funding).

His status to date is he is on the waiting list for a waiver. He has not had the support he needs. His primary care giver, mom (me), has not slept in weeks and his recovery is taking longer as we are too exhausted to do everything he needs. He needs to be moved in a different position every two hours at night when he is sleeping as he is still unable to move on his own. He is still using home school and has not been able to rejoin his classroom in our neighborhood school.

Please restore our funding to prior levels or open up the waiting list. I know people in our state are compassionate and caring. Please listen to their voices, listen to the voices of the disabled children of Minnesota.

Thank you.

Lisa Jo Bergren Salinas
4255 Dunrovin lane
Eagan, MN 55123

February 15, 2005

HEALTH AFFAIRS
The Policy Journal of the Health Sphere

HEALTH TRACKING
MARKETWATCH

2 February 2005

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MarketWatch: Illness And Injury As Contributors To Bankruptcy

Even universal coverage could leave many Americans vulnerable to bankruptcy unless such coverage was more comprehensive than many current policies.

by David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler

ABSTRACT:

In 2001, 1.458 million American families filed for bankruptcy. To investigate medical contributors to bankruptcy, we surveyed 1,771 personal bankruptcy filers in five federal courts and subsequently completed in-depth interviews with 931 of them. About half cited medical causes, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced medical bankruptcy. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage. Even middle-class insured families often fall prey to financial catastrophe when sick.

> If the debtor be insolvent to serve creditors, let his body be cut in pieces on the third market day. It may be cut into more or fewer pieces with impunity. Or, if his creditors consent to it, let him be sold to foreigners beyond the Tiber.
> —Twelve Tables, Table III, 6 (ca. 450 B.C.)

Our bankruptcy system works differently from that of ancient Rome; creditors carve up the debtor's assets, not the debtor. Even so, bankruptcy leaves painful problems in its wake. It remains on credit reports for a decade, making everything from car insurance to house payments more expensive.[1] Debtors' names are often published in the newspaper, and the fact of their bankruptcy may show up whenever someone tries to find them via the Internet. Potential employers who run routine credit checks (a common screening practice) will discover the bankruptcy, which can lead to embarrassment or, worse, the lost chance for a much-needed job.[2]

Personal bankruptcy is common. Nearly 1.5 million couples or individuals filed bankruptcy petitions in 2001, a 360 percent increase since 1980.[3] Fragmentary data from the legal literature suggest that illness and medical bills contribute to bankruptcy. Most previous studies of medical bankruptcy, however, have relied on court records—where medical debts may be subsumed under credit card or mortgage debt—or on responses to a single survey question.[4] None has collected detailed information on medical expenses, diagnoses, access to care, work loss, or insurance coverage. Research has been impeded both by the absence of a national repository for bankruptcy filings and by debtors' reticence to discuss their bankruptcy; in population-based surveys, only half of those who have undergone bankruptcy admit to it.[5]

The health policy literature is virtually silent on bankruptcy, although a few studies have looked at impoverishment attributable to illness. In his 1972 book, Sen. Edward Kennedy (D-MA) gave an impressionistic account of "sickness and bankruptcy."[6] The likelihood of incurring high out-of-pocket costs was incorporated into older estimates of the number of underinsured Americans: twenty-nine million in 1987.[7] About 16 percent of families now spend more than one-twentieth of their income on health care.[8] Among terminally ill patients (most of them insured), 39 percent reported that health care costs caused moderate or severe financial problems.[9] Medical debt is common among the poor, even those with insurance, and interferes with access to care.[10] At least 8 percent, and perhaps as many as 21 percent, of American families are contacted by collection agencies about medical bills annually.[11]

Our study provides the first extensive data on the medical concomitants of bankruptcy, based on a survey of debtors in bankruptcy courts. We address the following questions: (1) Who files for bankruptcy? (2) How frequently do illness and medical bills contribute to bankruptcy? (3) When medical bills contribute, how large are they and for what services? (4) Does inadequate health insurance play a role in bankruptcy? (5) Does bankruptcy compromise access to care?

A Brief Primer On Bankruptcy

"Bankrupt" is not synonymous with "broke." "Bankrupt" means filing a petition in a federal court asking for protection from creditors via the bankruptcy laws. A single petition may cover an individual or married couple. The instant a debtor files for bankruptcy, the court assumes legal control of the debtor's assets and halts all collection efforts.

Shortly after the filing, a court-appointed trustee convenes a meeting to inventory the debtor's assets and debts and to determine which assets are exempt from seizure. States may regulate these exemptions, which often include work tools, clothes, Bibles, and some equity in a home.

About 70 percent of all consumer debtors file under Chapter 7 of the Bankruptcy Code; most others file under Chapter 13. In Chapter 7 the trustee liquidates all nonexempt assets—although 96 percent of debtors have so little unencumbered property that there is nothing left to liquidate. At the conclusion of the bankruptcy, the debtor is freed from many debts. In Chapter 13 the debtor proposes a repayment plan, which extends for up to five years. Chapter 13 debtors may retain their property so long as they stay current with their repayments.

Under both chapters, taxes, student loans, alimony, and child support remain payable in full, and debtors must make payments on all secured loans (such as home mortgages and car loans) or forfeit the collateral.

Study Data And Methods

This study is based on a cohort of 1,771 bankruptcy filings in 2001. For each filing, a debtor completed a written questionnaire at the mandatory meeting with the trustee, and we abstracted financial data from public court records. In addition, we conducted follow-up telephone interviews with about half (931) of these debtors.

Sampling strategy. We used cluster sampling to assemble a cohort of households filing for personal bankruptcy in five (of the seventy-seven total) federal judicial districts.[12] We collected 250 questionnaires in each district, representative of the proportion of Chapters 7 and 13 filings in that district. These 1,250 cases constitute our "core sample." For planned studies on housing, we collected identical data from an additional 521 homeowners filing for bankruptcy. We based our analyses on all 1,771 bankruptcies with responses weighted to maintain the representativeness of the sample.[13]

Data collection. With the cooperation of the judges in each district, we contacted the trustees who officiate at meetings with debtors. The trustees agreed to distribute, or to allow a research assistant to distribute, a self-administered questionnaire to debtors appearing at the bankruptcy meeting. Questionnaires (which were available in English and Spanish) included a cover letter explaining the research project and human subjects protections and encouraging debtors to consult their attorneys (who were almost always present) before participating.

The questionnaire asked about demographics, employment, housing, and specific reasons for filing for bankruptcy; it also asked whether the debtor had medical debts exceeding $1,000, had lost two or more weeks of work-related income because of illness, or had health insurance coverage for themselves and all dependents at the time of filing, and whether there had been a gap of one month or more in that coverage during the past two years. In joint filings, we collected demographic information for each spouse.

During the spring and summer of 2001 we collected questionnaires from consecutive debtors in each district until the target number was reached.[14]

Follow-up telephone interviews. The written questionnaire distributed at the time of bankruptcy filing invited debtors to participate in future telephone interviews, for which they would receive $50; 70 percent agreed to such interviews. We ultimately completed follow-up telephone interviews with 931 of the 1,771 debtor families, a response rate of 53 percent.[15] The telephone interviews, conducted between June 2001 and February 2002 using a structured, computer-assisted protocol, explored financial, housing, and medical issues. Many debtors also provided a narrative description of their bankruptcy experience.

Detailed medical questions. Each of the 931 interviewees was asked if any of the following had been a significant cause of their bankruptcy: an illness or injury; the death of a family member; or the addition of a family member through birth, adoption, custody, or fostering. Those who answered yes to this screening question were queried about diagnoses, health insurance during the illness, and medical care use and spending. Interviewers collected information about each household member with medical problems. In total, we collected in-depth medical information on 391 people with health problems in 332 debtor households.

Data analysis. We used data from the self-administered questionnaires (and court records) obtained from all 1,771 filers to analyze demographics, health coverage at the time of filing, and gaps in coverage in the two years before filing.

We also used the questionnaire to estimate how frequently illness and medical bills contributed to bankruptcy. We developed two summary measures of medical bankruptcy. Under the rubric "Major Medical Bankruptcy" we included debtors who either (1) cited illness or injury as a specific reason for bankruptcy, or (2) reported uncovered medical bills exceeding $1,000 in the past years, or (3) lost at least two weeks of work-related income because of illness/injury, or (4) mortgaged a home to pay medical bills. Our more inclusive category, "Any Medical Bankruptcy," included debtors who cited any of the above, or addiction, or uncontrolled gambling, or birth, or the death of a family member.[16]

Data from the 931 follow-up telephone interviews were used to analyze hardships experienced by debtors in the period surrounding their bankruptcy, including problems gaining access to medical care. The in-depth medical interviews regarding 391 people with medical problems are the basis for our analyses of which household members were ill, diagnoses, health insurance at onset of illness, and out-of-pocket spending. Two physicians (Himmelstein and Woolhandler) coded the diagnoses given by debtors into categories for analysis.

SAS and SUDAAN were used for statistical analyses, adjusting for complex sample design. To extrapolate our findings nationally, we assumed that our core sample was representative of the 1,457,572 households filing for bankruptcy during 2001. Human subject committees at Harvard Law School and the Cambridge Hospital approved the project.

Study Findings

Who files for bankruptcy? Exhibit 1 displays the demographic characteristics of our weighted sample of 1,771 bankruptcy filers. The average debtor was a forty-one-year-old woman with children and at least some college education. Most debtors owned homes; their occupational prestige scores place them predominantly in the middle or working classes.

Exhibit 1.

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On average, each bankruptcy involved 1.32 debtors (reflecting some joint filings by married couples) and 1.33 dependents. Extrapolating from our data, the 1.5 million personal bankruptcy filings nationally in 2001 involved 3.9 million people: 1.9 million debtors, 1.3 million children under age eighteen, and 0.7 million other dependents.

Medical causes of bankruptcy. Exhibit 2 shows the proportion of debtors (N = 1,771) citing various medical contributors to their bankruptcy and the estimated number of debtors and dependents nationally affected by each cause. More than one-quarter cited illness or injury as a specific reason for bankruptcy; a similar number reported uncovered medical bills exceeding $1,000. Some debtors cited more than one medical contributor. Nearly half (46.2 percent) (95 percent confidence interval = 43.5, 48.9) of debtors met at least one of our criteria for "major medical bankruptcy." Slightly more than half (54.5 percent) (95 percent CI = 51.8, 57.2) met criteria for "any medical bankruptcy."

A lapse in health insurance coverage during the two years before filing was a strong predictor of a medical cause of bankruptcy (Exhibit 3). Nearly four-tenths (38.4 percent) of debtors who had a "major medical bankruptcy" had experienced a lapse, compared with 27.1 percent of debtors with no medical cause ($p < .0001$). Surprisingly, medical debtors were no less likely than other debtors to have coverage at the time of filing. (More detailed coverage and cost data for the subsample we interviewed appears below.)

Exhibit 3.

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Medical debtors resembled other debtors in most other respects (Exhibit 1). However, the "major medical bankruptcy" group was 16 percent ($p < .03$) less likely than other debtors to cite trouble managing money as a cause of their bankruptcy (data not shown).

Privations in the period surrounding bankruptcy. In our follow-up telephone interviews with 931 debtors, they reported substantial privations. During the two years before filing, 40.3 percent had lost telephone service; 19.4 ercent had gone without food; 53.6 percent had gone without needed doctor or dentist visits because of the cost; and 43.0 percent had failed to fill a prescription, also because of the cost. Medical debtors experienced more problems in access to care than other debtors did; three-fifths went without a needed doctor or dentist visit, and nearly half failed to fill a prescription (Exhibit 4).

Exhibit 4.

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Medical debt was also associated with mortgage problems. Among the total sample of 1,771 debtors, those with more than $1,000 in medical bills were more likely than others to have taken out a mortgage to pay medical bills (5.0 percent versus 0.8 percent). Fifteen percent of all homeowners who had taken out a second or third mortgage cited medical expenses as a reason. Follow-up phone interviews revealed that among homeowners with high-cost mortgages (interest rates greater than 12 percent, or points plus fees of at least 8 percent), 13.8 percent cited a medical reason for taking out the loan.

Following their bankruptcy filings, about one-third of debtors continued to have problems paying their bills. Medical debtors reported particular problems making mortgage/ rent payments and paying for utilities (Exhibit 4). Although ır interviews occurred soon after the bankruptcy filings (seven months, on average), many debtors had already been turned down for jobs (3.1 percent), mortgages (5.8 percent), apartment rentals (4.9 percent), or car loans (9.3 percent) because of the bankruptcy on their credit reports.

Medical diagnoses, spending, and type of coverage. Our interviews yielded detailed data on diagnoses, health insurance coverage, and medical bills for 391 debtors or family members whose medical problems contributed to bankruptcy. In three-quarters of cases, the person experiencing the illness/ injury was the debtor or spouse of the debtor; in 13.3 percent, a child; and in 8.2 percent, an elderly relative.

Illness begot financial problems both directly (because of medical costs) and through lost income. Three-fifths (59.9 percent) of families bankrupted by medical problems indicated that medical bills (from medical care providers) contributed to bankruptcy; 47.6 percent cited drug costs; 35.3 percent had curtailed employment because of illness,

often (52.8 percent) to care for someone else. Many families had problems with both medical bills and income loss.

Families bankrupted by medical problems cited varied, and sometimes multiple, diagnoses. Cardiovascular disorders were reported by 26.6 percent; trauma/orthopedic/back problems by nearly one-third; and cancer, diabetes, pulmonary, or mental disorders and childbirth-related and congenital disorders by about 10 percent each. Half (51.7 percent) of the medical problems involved ongoing chronic illnesses.

Our in-depth interviews with medical debtors confirmed that gaps in coverage were a common problem. Three-fourths (75.7 percent) of these debtors were insured at the onset of the bankrupting illness. Three-fifths (60.1 percent) initially had private coverage, but one-third of them lost coverage during the course of their illness. Of debtors, 5.7 percent had Medicare, 8.4 percent Medicaid, and 1.6 percent veterans/military coverage. Those covered under government programs were less likely than others to have experienced coverage interruptions.

Few medical debtors had elected to go without coverage. Only 2.9 percent of those who were uninsured or suffered a gap in coverage said that they had not thought they needed insurance; 55.9 percent said that premiums were unaffordable; 7.1 percent were unable to obtain coverage because of preexisting medical conditions; and most others cited employment issues, such as job loss or ineligibility for employer-sponsored coverage.

Debtors' out-of-pocket medical costs were often below levels that are commonly labeled catastrophic. In the year prior to bankruptcy, out-of-pocket costs (excluding insurance premiums) averaged $3,686 (95 percent CI = $2,693, $4,679) (Exhibit 5). Presumably, such costs were often ruinous because of concomitant income loss or because the need for costly care persisted over several years. Out-of-pocket costs since the onset of illness/injury averaged $11,854 (95 percent CI = $8,532, $15,175). Those with continuous insurance coverage paid $734 annually in premiums on average, over and above the expenditures detailed above. Debtors with private insurance at the onset of their illnesses had even higher out-of-pocket costs than those with no insurance (Exhibit 5). This paradox is explained by the very high costs—$18,005—incurred by patients who initially had private insurance but lost it. Among families with medical expenses, hospital bills were the biggest medical expense for 42.5 percent, prescription medications for 21.0 percent, and doctors' bills for 20.0 percent. Virtually all of those with Medicare coverage, and most patients with psychiatric disorders, said that prescription drugs were their biggest expense.

Exhibit 5.

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The human face of bankruptcy. Debtors' narratives painted a picture of families arriving at the bankruptcy courthouse emotionally and financially exhausted, hoping to stop the collection calls, save their homes, and stabilize their economic circumstances. Many of the debtors detailed ongoing problems with access to care. Some expressed fear that their medical care providers would refuse to continue their care, and a few recounted actual experiences of this kind. Several had used credit cards to charge medical bills they had no hope of paying.

The co-occurrence of medical and job problems was a common theme. For instance, one debtor underwent lung surgery and suffered a heart attack. Both hospitalizations were covered by his employer-based insurance, but he was unable to return to his physically demanding job. He found new employment but was denied coverage because of his preexisting conditions, which required costly ongoing care. Similarly, a teacher who suffered a heart attack was unable to return to work for many months, and hence her coverage lapsed. A hospital wrote off her $20,000 debt, but she was nonetheless bankrupted by doctors' bills and the cost of medications.

A second common theme was sounded by parents of premature infants or chronically ill children; many took time off from work or incurred large bills for home care while they were at their jobs.

Finally, many of the insured debtors blamed high copayments and deductibles for their financial ruin. For example, a man insured through his employer (a large national firm) suffered a broken leg and torn knee ligaments. He incurred $13,000 in out-of-pocket costs for copayments, deductibles, and uncovered services—much of it for physical therapy.

Discussion

Bankruptcy is common in the United States, involving nearly four million debtors and dependents in 2001; medical problems contribute to about half of all bankruptcies. Medical debtors, like other bankruptcy filers, were primarily

middle class (by education and occupation). The chronically poor are less likely to build up debt, have fewer assets (such as a home) to protect, and have less access to the legal resources needed to navigate a complex financial rehabilitation. The medical debtors we surveyed were demographically typical Americans who got sick. They differed from others filing for bankruptcy in one important respect: They were more likely to have experienced a lapse in health coverage. Many had coverage at the onset of their illness but lost it. In other cases, even continuous coverage left families with ruinous medical bills.

Study strengths and limitations. Our study's strengths are the use of multiple overlapping data sources; a large sample size; geographic diversity; and in-depth data collection. Although our sample may not be fully representative of all personal bankruptcies, the Chapter 7 filers we studied resemble Chapter 7 filers nationally (the only group for whom demographic data has been compiled nationally from court records).[17] Several indicators suggest that response bias did not greatly distort our findings.[18]

As in all surveys, we relied on respondents' truthfulness. Might some debtors blame their predicament on socially acceptable medical problems rather than admitting to irresponsible spending? Several factors suggest that our respondents were candid. First, just prior to answering our questionnaire, debtors had filed extensive financial information with the court under penalty of perjury—information that was available to us in the court records and that virtually never contradicted the questionnaire data. They were about to be sworn in by a trustee (who often administered our questionnaire) and examined under oath. At few other points in life are full disclosure and honesty so aggressively emphasized.

Second, the details called for in our telephone interview—questions about out-of-pocket medical expenses, who was ill, diagnoses, and so forth—would make a generic claim that "we had medical problems" difficult to sustain. Third, one of us (Thorne) interviewed (for other studies) many debtors in their homes. Almost all specifically denied spendthrift habits, and observation of their homes supported these claims. Most reflected the lifestyle of people under economic constraint, with modest furnishings and few luxuries. Finally, our findings receive indirect corroboration from recent surveys of the general public that have found high levels of medical debt, which often result in calls from collection agencies.[19]

Even when data are reliable, making causal inferences from a cross-sectional study such as ours is perilous. Many debtors described a complex web of problems involving illness, work, and family. Dissecting medical from other causes of bankruptcy is difficult. We cannot presume that eliminating the medical antecedents of bankruptcy would have prevented all of the filings we classified as "medical bankruptcies." Conversely, many people financially ruined by illness are undoubtedly too ill, too destitute, or too demoralized to pursue formal bankruptcy. In sum, bankruptcy is an imperfect proxy for financial ruin.

Trends in medical bankruptcy. Although methodological inconsistencies between studies preclude precise quantification of time trends, medical bankruptcies are clearly increasing. In 1981 the best evidence available suggests that about 25,000 families filed for bankruptcy in the aftermath of a serious medical problem (8 percent of the 312,000 bankruptcy filings that year).[20] Our findings suggest that the number of medical bankruptcies had increased twenty-threefold by 2001. Since the number of bankruptcy filings rose 11 percent in the eighteen months after the completion of our data collection, the absolute number of medical bankruptcies almost surely continues to increase.[21]

Policy implications. Our data highlight four deficiencies in the financial safety net for American families confronting illness. First, even brief lapses in insurance coverage may be ruinous and should not be viewed as benign. While forty-five million Americans are uninsured at any point in time, many more experience spells without coverage. We found little evidence that such gaps were voluntary. Only a handful of medical debtors with a gap in coverage had chosen to forgo insurance because they had not perceived a need for it; the overwhelming majority had found coverage unaffordable or effectively unavailable. The privations suffered by many debtors—going without food, telephone service, electricity, and health care—lend credence to claims that coverage was unaffordable and belie the common perception that bankruptcy is an "easy way out."

Second, many health insurance policies prove to be too skimpy in the face of serious illness. We doubt that such underinsurance reflects families' preference for risk; few Americans have more than one or two health insurance options. Many insured families are bankrupted by medical expenses well below the "catastrophic" thresholds of high-deductible plans that are increasingly popular with employers. Indeed, even the most comprehensive plan available to us through Harvard University leaves faculty at risk for out-of-pocket expenses as large as those reported by our medical debtors.

Third, even good employment-based coverage sometimes fails to protect families, because illness may lead to job loss and the consequent loss of coverage. Lost jobs, of course, also leave families without health coverage when they are at their financially most vulnerable.

Finally, illness often leads to financial catastrophe through loss of income, as well as high medical bills. Hence, disability insurance and paid sick leave are also critical to financial survival of a serious illness.

Only broad reforms can address these problems. Even universal coverage could leave many Americans vulnerable to bankruptcy unless such coverage was much more comprehensive than many current policies. As in Canada and most of western Europe, health insurance should be divorced from employment to avoid coverage disruptions at the time of illness. Insurance policies should incorporate comprehensive stop-loss provisions, closing coverage loopholes that expose insured families to unaffordable out-of-pocket costs. Additionally, improved programs are needed to replace breadwinners' incomes when they are disabled or must care for a loved one. The low rate of medical bankruptcy in Canada suggests that better medical and social insurance could greatly ameliorate this problem in the United States.[22]

In 1591 Pope Gregory XIV fell gravely ill. His doctors prescribed pulverized gold and gems. According to legend, the resulting depletion of the papal treasury is reflected in his unadorned plaster sarcophagus in St. Peter's Basilica.[23] Four centuries later, solidly middle-class Americans still face impoverishment following a serious illness.

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NOTES

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12. The districts were California (Central District); Illinois (Northern District); Pennsylvania (Eastern District); Tennessee (Middle District); and Texas (Northern District). These were chosen to achieve geographic, social, and legal diversity. Together the five districts accounted for 13.8 percent of total U.S. bankruptcy filings in 2001.
13. The 521 extra homeowner cases make the full sample of 1,771 less representative of filers nationally than our core sample of 1,250. Therefore, we used weighting procedures to adjust for the oversampling of debtors in three districts, homeowners, and debtors filing under Chapter 13. The weighted and unweighted findings were little different.
14. Interviews with trustees indicate that response rates in the five districts varied from approximately 55 percent to nearly 100 percent.
15. It proved difficult to contact some debtors, presumably because they were experiencing major life disruptions or were afraid of calls from creditors. After ten unsuccessful attempts to telephone potential subjects, we attempted to reach them through contacts they had previously given us and via a letter. Relative to the overall sample, the 931 interviewed debtors were slightly less likely to be male, to have lost a home, or to reside outside of Illinois but did not differ in age, occupational prestige score, education, or home ownership. On occupational prestige scores, see NORC, "Occupational Prestige Studies/Summary," cloud9.norc.uchicago.edu/faqs/prestige .htm (13 December 2004).
16. Uncontrolled gambling is classified as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV) and contributed to about 1 percent of the bankruptcies.
17. Our Chapter 7 filers are similar to those nationally in income, home ownership, family size, age distribution, and

marital status. See E. Flynn et al., "Bankruptcy by the Numbers," *ABI Journal* 20, no. 10 (2002): 28–29; 21, no. 3 (2002): 22, 49; and 20, no. 8 (2001): 20.

18. We achieved high response rates to our initial questionnaire, and rates of medical bankruptcy varied little between districts despite some variation in response rates. It seems plausible that more-stigmatized causes of bankruptcy (such as addiction, mental illness, or profligate spending) may be underreported.

19. Twelve percent of households reported unpaid medical debts in 1997, with 691,000 households reporting outstanding medical debts greater than $5,000. SMR Research Corporation, *The New Bankruptcy Epidemic* (Hackettstown, N.J.: SMR, 2001), 127. A high incidence of collection agency calls was reported in NPR/Kaiser et al., "National Survey on Health Care"; May et al., *Tough Trade-Offs*; and Collins et al., *The Affordability Crisis.*

20. For the total number of bankruptcies, see U.S. Bureau of the Census, *Statistical Abstract of the United States: 1986* (Washington: GPO, 1985). The estimate that 8 percent of these were medical is from T.A. Sullivan, E. Warren, and J.L. Westbrook, *The Fragile Middle Class: Americans in Debt* (New Haven, Conn.: Yale University Press, 2000).

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22. Between 7.1 percent and 14.3 percent of Canadian bankruptcies are attributable to "health/misfortune." See J.S. Ziegel, "A Canadian Perspective," *Texas Law Review* 79, no. 5 (2001): 241–256.

23. *Rome/Vatican City* (Clermont-Ferrand, France: Michelin Travel Publications, 2001).

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EXHIBIT 1
Demographic Characteristics Of Primary Debtors In Bankruptcy Filings, 2001

	All bankruptcies	Major medical bankruptcies[a]
Median age (years)	41	42
Percent male[b]	45.1%	44.2%
Percent of households filing under Chapter 7	62.2%	62.3%
Average number of debtors and dependents per bankruptcy	2.65	2.75
Percent with at least some college education	53.5%	55.8%
Percent current homeowners or lost home in past 5 years	55.3%	56.5%
Percent with occupational prestige scores above 20	81.2%	80.0%
Median income in year prior to bankruptcy filing	$25,000	$24,500

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

NOTE: $P > .05$ for all comparisons between debtors with a major medical cause and other debtors.

[a] Bankruptcies meeting at least one of the following criteria: Illness or injury listed as specific reason, uncovered medical bills exceeding $1,000, lost at least two weeks of work-related income because of illness/injury, or mortgaged home to pay medical bills.

[b] Data are for primary and secondary debtors combined.

EXHIBIT 2
Medical Causes Of Bankruptcy, 2001

	Percent of bankruptcies	Number of debtors and dependents in affected U.S. families annually[a]
Specific reason for bankruptcy cited by debtor		
Illness or injury	28.3	1,039,880
Birth/addition of new family member	7.7	421,256
Death in family	7.6	281,309
Alcohol or drug addiction	2.5	109,180
Uncontrolled gambling	1.2	39,566
Debtor or spouse lost at least 2 weeks of work-related income because of illness/injury	21.3	825,113
Uncovered medical bills exceeding $1,000 in 2 years before filing	27.0	1,150,302
Mortgaged home to pay medical bills	2.0[b]	64,000
Major medical cause (illness or injury listed as specific reason, or uncovered medical bills exceeding $1,000, or lost at least 2 weeks of work-related income because of illness/injury, or mortgaged home to pay medical bills)	46.2	1,850,098
Any medical cause (any of the above)	54.5	2,227,000

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

[a]Extrapolation based on number of bankruptcy filings during 2001 and household size of debtors citing each cause.

[b]Percentage based on homeowners rather than all debtors.

EXHIBIT 3
Health Insurance Status Of Debtors With And Without Medical Causes Of Bankruptcy, 2001

	Percent of debtors citing any medical cause of bankruptcy[a]	Percent of debtors citing major medical cause of bankruptcy[b]	Percent of debtors citing no medical cause of bankruptcy
Debtor or a dependent uninsured at time of bankruptcy filing	32.0[c]	32.6[c]	34.5
Debtor or a dependent had a lapse in coverage during past 2 years	37.7****	38.4****	27.1

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

[a]Bankruptcy meeting one or more of the following criteria: illness, injury, addition to family, death, alcoholism, drug addiction, or uncontrolled gambling as reason for bankruptcy; or debtor/spouse lost at least 2 weeks of work-related income because of illness/injury; or uncovered medical bills exceeding $1,000; or mortgaged home to pay medical bills.

[b]Bankruptcy meeting one or more of the following criteria: illness or injury as specific reason for bankruptcy; or uncovered medical bills exceeding $1,000; or debtor/spouse lost at least 2 weeks of work-related income because of illness/injury; or mortgaged home to pay medical bills.

[c]*p* not significant for comparison to debtors citing no medical cause of bankruptcy.

****$p < .001$ for comparison to debtors citing no medical cause of bankruptcy.

EXHIBIT 4
Privations Experienced By Households In The Period Surrounding Bankruptcy, 2001

Privation in households reporting problems due to finances in the 24 months before filing for bankruptcy	Any medical cause of bankruptcy[a]	Major medical cause of bankruptcy[b]	No medical cause of bankruptcy
Went without food	21.1%[c]	21.8%[c]	17.0%
Water or electricity shut off	30.2[c]	29.8[c]	26.4
Lost phone service	43.4[c]	43.6[c]	35.9
Moved because of financial difficulties	17.0[c]	17.8[c]	14.3
Lost insurance (home, car, life, or health)	47.4****	46.7***	34.6
Went without a needed doctor/dentist visit	59.5****	60.7****	45.0
Failed to fill a prescription	46.7**	49.6***	37.6
Changed care arrangements for an elderly relative	6.7**	6.7**	2.7
Privation in households reporting continuing financial problems 3–12 months after filing for bankruptcy			
Any problem paying bills	32.7[c]	31.1[c]	27.5
Problem paying mortgage/rent	13.8**	12.9[c]	9.1
Problem paying utilities	15.7**	14.9[c]	9.6

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

[a]Bankruptcy meeting one or more of the following criteria: illness, injury, addition to family, death, alcoholism, drug addiction, or uncontrolled gambling as reason for bankruptcy; or debtor/spouse lost at least two weeks of work-related income beoause of illness/injury; or uncovered medical bills exceeding $1,000; or mortgaged home to pay medical bills. *P* values are for comparisons to bankrupt households citing no medical cause of bankruptcy.

[b]Bankruptcy meeting one or more of the following criteria: illness or injury as specific reason for bankruptcy; or uncovered medical bills exceeding $1,000; or debtor/spouse lost at least two weeks of work-related income because of illness/injury; or mortgaged home to pay medical bills. *P* values are for comparisons to bankrupt households citing no major medical cause of bankruptcy.

[c]Not significant ($p > .05$).

*$p < .10$ **$p < .05$ ***$p < .01$ ****$p < .001$

EXHIBIT 5
Out-Of-Pocket Medical Spending Since Illness Onset Of Debtors Citing Medical Reasons For Bankruptcy, By Insurance Coverage And Diagnosis, 2001

Group	Mean out-of-pocket expenditure ($)
All debtors citing medical reasons	11,854
Insurance at onset of illness	
Private	13,460
Medicare	8,118
Medicaid	8,195
Uninsured	10,893
Covered at onset of illness but gap since then	
Yes	14,339
No	9,898
Highest-cost diagnoses	
Cancer	35,878
Neurologic diseases	15,560
Mental disorders	15,478
Death (any cause)	17,283

SOURCE: Authors' analysis of data from the Consumer Bankruptcy Project.

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Sick and Broke
By Elizabeth Warren
The Washington Post

Wednesday 09 February 2005

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Nobody's safe. That's the warning from the first large-scale study of medical bankruptcy.

Health insurance? That didn't protect 1 million Americans who were financially ruined by illness or medical bills last year.

i issues

A comfortable middle-class lifestyle? Good education? Decent job? No safeguards there. Most of the medically bankrupt were middle-class homeowners who had been to college and had responsible jobs -- until illness struck.

As part of a research study at Harvard University, our researchers interviewed 1,771 Americans in bankruptcy courts across the country. To our surprise, half said that illness or medical bills drove them to bankruptcy. So each year, 2 million Americans -- those who file and their dependents -- face the double disaster of illness and bankruptcy.

e environment

But the bigger surprise was that three-quarters of the medically bankrupt had health insurance.

How did illness bankrupt middle-class Americans with health insurance? For some, high co-payments, deductibles, exclusions from coverage and other loopholes left them holding the bag for thousands of dollars in out-of-pocket costs when serious illness struck. But even families with Cadillac coverage were often bankrupted by medical problems.

m multimedia

Too sick to work, they suddenly lost their jobs. With the jobs went most of their income and their health insurance -- a quarter of all employers cancel coverage the day you leave work because of a disabling illness; another quarter do so in less than a year. Many of the medically bankrupt qualified for some disability payments (eventually), and had the right under the COBRA law to continue their health coverage -- if they paid for it themselves. But how many families can afford a $1,000 monthly premium for coverage under COBRA, especially after the breadwinner has lost his or her job?

c contact

Often, the medical bills arrived just as the insurance and the paycheck disappeared.

Bankrupt families lost more than just assets. One out of five went without food. A third had their utilities shut off, and nearly two-thirds skipped needed doctor or dentist visits. These families struggled to stay out of bankruptcy. They arrived at the

bankruptcy courthouse exhausted and emotionally spent, brought low by a health care system that could offer physical cures but that left them financially devastated.

Many in Congress have a response to the problem of the growing number of medical bankruptcies: make it harder for families to file bankruptcy regardless of the reason for their financial troubles. Bankruptcy legislation -- widely known as the credit industry wish list -- has been introduced yet again to increase costs and decrease protection for every family that turns to the bankruptcy system for help. With the dramatic rise in medical bankruptcies now documented, this tired approach would be no different than a congressional demand to close hospitals in response to a flu epidemic. Making bankruptcy harder puts the fallout from a broken health care system back on families, leaving them with no escape.

The problem is not in the bankruptcy laws. The problem is in the health care finance system and in chronic debates about reforming it. The Harvard study shows:

- Health insurance isn't an on-off switch, giving full protection to everyone who has it. There is real coverage and there is faux coverage. Policies that can be canceled when you need them most are often useless. So is bare-bones coverage like the Utah Medicaid program pioneered by new Health and Human Services Secretary Mike Leavitt; it pays for primary care visits but not specialists or hospital care. We need to talk about quality, durable coverage, not just about how to get more names listed on nearly-useless insurance policies.

- The link between jobs and health insurance is strained beyond the breaking point. A harsh fact of life in America is that illness leads to job loss, and that can mean a double kick when people lose their insurance. Promising them high-priced coverage through COBRA is meaningless if they can't afford to pay. Comprehensive health insurance is the only real solution, not just for the poor but for middle-class Americans as well.

Without better coverage, millions more Americans will be hit by medical bankruptcy over the next decade. It will not be limited to the poorly educated, the barely employed or the uninsured. The people financially devastated by a serious illness are at the heart of the middle class.

Every 30 seconds in the United States, someone files for bankruptcy in the aftermath of a serious health problem. Time is running out. A broken health care system is bankrupting families across this country.

The writer is a law professor at Harvard University.

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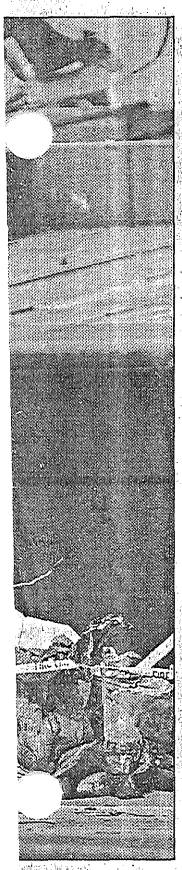

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NATION & WORLD BRIEFING

Bush rallies GOP lawmakers

WHITE SULPHUR SPRINGS, W. Va. — President Bush rallied congressional Republicans attending a GOP luncheon retreat on behalf of his second-term program Friday, saying, "I think we've proven to the country we know how to set an agenda and ... achieve it." He also previewed his State of the Union address on Wednesday. "I will remind the country we're still at war," he said, adding he wanted to thank "Congress for providing the necessary support for our troops who are in harm's way." He also said Social Security shortfalls would be addressed and that he would "continue to articulate the faith-based agenda." His proposal to add private investment accounts to Social Security is drawing the fire of critics, including some party faithful at the retreat. The president plans a two-day blitz next week in the Midwest and Florida to promote his plan.

For more on this story, go to www.twincities.com/news and click on Nation/World.

'Lost' Los Alamos disks never existed

ALBUQUERQUE, N.M. — Two computer disks that supposedly disappeared last summer — prompting a virtual shutdown of the Los Alamos National Laboratory — never existed, according to report released Friday. In a harsh review, the U.S. Energy Department concluded that bar codes were recorded for the disks but the disks themselves were never created. The Energy Department has slashed by two-thirds the management fee it paid to the University of California to run the nuclear lab.

Federal judge bars Medicaid cuts

NASHVILLE, Tenn. — A judge Friday blocked Tennessee Gov. Phil Bredesen from removing 323,000 adults from the state's expanded Medicaid program, cutbacks that the governor says are necessary to keep the roughly $8 billion program from bankrupting the state. The state said it was immediately appealing U.S. District Court Judge William Haynes' decision to the 6th U.S. Circuit Court of Appeals.

Key figure in deadly IRA bombing freed

DUBLIN, Ireland — The only man convicted in connection with Northern Ireland's deadliest bombing in 1988 walked free from prison Friday after winning an appeal and posting bail. Three years ago, Colm Murphy, 52, received a 14-year sentence for allegedly supplying two cell phones to IRA dissidents who detonated a car bomb in the town of Omagh, killing 29 people and wounding more than 300. But last week, appellate judges threw out his conviction after finding that two detectives who interrogated Murphy in 1999 rewrote their interview notes, then denied doing so under oath. The two face trial on perjury charges. On Friday, Murphy, 52, went straight to a pub with friends after his release. Relatives of the bombing victims have expressed outrage at his release.

Homeland nominee asked about torture

WASHINGTON — Michael Chertoff, who has been picked by President Bush to be the homeland security secretary, advised the CIA on the legality of coercive interrogation methods, officials say. He said that some coercive methods could be legal, but advised against others. Chertoff's previously undisclosed involvement in evaluating how far interrogators could go occurred from 2002 to 2003 when he headed Justice's criminal unit. Asked about the interaction between the CIA and Chertoff, a White House spokeswoman, said, "Judge Chertoff did not approve interrogation techniques as head of the criminal division."

Oxford to study faith-pain link

LONDON — In an experiment supported by a U.S.-based foundation, Oxford University scientists will inflict pain on volunteers to determine whether belief in God helps relieve suffering. The pain may come from heat pads applied to the backs of the hand or from a gel made from chili peppers. Electrical activity in the brain will be measured to see whether subjects who draw on religious beliefs handle pain differently. "That will enable us to look at the subjective element of pain and how it is alleviated," said Susan Greenfield, a professor at Oxford, who heads the Center for Science of the Mind, supported by a $2 million grant from the John Templeton Foundation.

Priest's accuser returns to stand

CAMBRIDGE, Mass. — The man accusing defrocked priest Paul Shanley of sexually abusing him as a child finished his testimony Friday, despite begging the judge a day earlier to spare him from a third day of questioning. The man adamantly stood by his claims of abuse before stepping down from the stand after 10 hours of testimony, much of that under grueling cross-examination. The man is the lone remaining accuser in the case against the 74-year-old former priest, a central figure in the Boston Archdiocese's sex abuse scandal. The 27-year-old firefighter testified that Shanley raped and molested him, beginning when he was 6.

Cadets face censure for Nazi costumes

WASHINGTON — Virginia Military Institute has asked a student governing body to investigate and recommend discipline against cadets who went to a Halloween party wearing costumes that parodied Nazis, Africans and homosexuals. In a photo on a Web site, three young men wearing black shirts pose as Nazis with their right arms extended in a stiff-armed salute. The General Committee will investigate the case.

Sen. Berglund,

My apologies. I got lost in the tunnels (after I had a problem finding parking.)

Lona DeCarlo