

2-27-2020

Reorganizing Healthcare Bankruptcy

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Recommended Citation

Laura N. Coordes, *Reorganizing Healthcare Bankruptcy*, 61 B.C.L. Rev. 419 (2020), <https://lawdigitalcommons.bc.edu/bclr/vol61/iss2/2>

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LAURA N. COORDES

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REORGANIZING HEALTHCARE BANKRUPTCY

LAURA N. COORDES*

Abstract: Many healthcare providers are experiencing financial distress, and if the predicted wave of healthcare bankruptcies materializes, the entire U.S. economy could suffer. Unfortunately, healthcare providers are part of a growing group of “bankruptcy misfits,” in the sense that bankruptcy does not work for them the way it works for other businesses. This is so for two primary reasons. First, the Bankruptcy Code (“Code”) is insufficiently specific with respect to healthcare debtors. Second, the Code lacks an organizing principle to allow courts to reconcile the competing players and interests in healthcare bankruptcy cases. Previous attempts to address these issues have not succeeded. Notably, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 scattered reforms across the Code, which made bankruptcy more complicated for healthcare debtors. As a result, some have argued that these debtors are better off using bankruptcy alternatives, such as state receiverships, to address their debts. This Article asserts that despite their bankruptcy misfit status, healthcare providers can realize distinct benefits from bankruptcy relief. To be effective, however, this relief must respond to healthcare providers’ unique needs. Creating separate Code subchapters for healthcare business bankruptcies would allow Congress to clarify many aspects of healthcare bankruptcy and enable the development of specific procedures and a distinct organizing principle unique to healthcare provider bankruptcies. Although this proposal contemplates a significant structural change to the Code, this Article explains why this change is warranted as part of the Code’s necessary evolution.

INTRODUCTION

U.S. healthcare is a large and expensive industry. According to estimates from the Centers for Medicare & Medicaid Services (CMS), the health share of

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gross domestic product (GDP) will reach nearly twenty percent by 2025.¹ Health spending totaled almost \$3.4 trillion in 2016²—about twice as much as any other industrialized nation spends on healthcare and almost two-thirds the amount spent on retail and food services that year³—and CMS predicts that national health expenditure growth will outpace GDP growth at least through 2026.⁴ This massive annual spending growth threatens the national economy by “crowding out other productive investments such as infrastructure and education.”⁵

Despite the trillions of dollars that the United States pours into healthcare on an annual basis, the industry is on the verge of a serious financial crisis.⁶ The healthcare industry regularly grapples with numerous problems, including increased competition, legislative uncertainty, changing payment models, higher pharmaceutical costs, and rising wages.⁷ Due in part to these issues, in 2016 alone, three of the country’s most established healthcare facilities—Partners HealthCare, the Cleveland Clinic, and MD Anderson—began hemorrhaging money.⁸

A healthcare provider’s financial distress impacts much more than the provider’s bottom line. Healthcare institutions provide critically needed ser-

¹ Press Release, Ctrs. for Medicare & Medicaid Servs., 2016–2025 Projections of National Health Expenditures Data Released (Feb. 15, 2017), <https://www.cms.gov/newsroom/press-releases/2016-2025-projections-national-health-expenditures-data-released> [<https://perma.cc/37Q2-C99Y>].

² *Id.*

³ See Nicholas Rossolillo, *What We Learned from the 2016 Retail Sales Numbers*, MOTLEY FOOL (Nov. 21, 2018), <https://www.fool.com/investing/2017/01/27/what-we-learned-from-the-2016-retail-sales-numbers.aspx> [<https://perma.cc/JZ9C-5BFB>] (“On the year, total retail and food services spending increased 3.3% over 2015 to \$5.5 trillion.”).

⁴ John Commins, *Healthcare Spending at 20% of GDP? That’s an Economy-Wide Problem*, HEALTHLEADERS (Sept. 19, 2018), <https://www.healthleadersmedia.com/finance/healthcare-spending-20-gdp-thats-economy-wide-problem> [<https://perma.cc/M8Z4-S8WD>].

⁵ *Id.*

⁶ See Ryan Cooper, Opinion, *The Slow-Motion Collapse of the American Health-Care System*, THE WEEK (Nov. 30, 2018), <https://theweek.com/articles/809992/slowmotion-collapse-american-healthcare-system> [<https://perma.cc/YC93-QCLE>] (linking problems with suicides and drug overdoses to “America’s bloated, Kafkaesque nightmare of a health-care system, which is slow[ly] collapsing before our very eyes”).

⁷ Mark G. Douglas, *Focus on Health Care Provider Bankruptcies*, JONES DAY (Sept.–Oct. 2017), <http://www.jonesday.com/Focus-on-Health-Care-Provider-Bankruptcies-10-01-2017/> [<https://perma.cc/H5RW-ELGF>]; see Sheryl Gay Stolberg et al., *Ruling Striking Down Obamacare Moves Health Debate to Center Stage*, N.Y. TIMES (Dec. 15, 2018), <https://www.nytimes.com/2018/12/15/us/politics/obamacare-ruling-health-care.html?action=click&module=Top%20Stories&pgtype=Homepage> [<https://perma.cc/VS2V-MZQE>] (describing how a Texas judge’s decision to strike down the Affordable Care Act may “imperil[] the insurance coverage of millions of Americans”).

⁸ Robert Pearl, *Why Major Hospitals Are Losing Money by the Millions*, FORBES (Nov. 7, 2017), <https://www.forbes.com/sites/robertpearl/2017/11/07/hospitals-losing-millions/#4489aebb7b50> [<https://perma.cc/6EPD-7KBA>].

vices to the U.S. population.⁹ As healthcare providers reduce staff, cut spending, and even shut down entirely in some cases, large swaths of the country are left without access to adequate care.¹⁰ Inadequate treatment, in turn, leads to “thousands of needless deaths each year,” affecting the U.S. population and the economy at large.¹¹

A financially distressed healthcare institution might reasonably consider bankruptcy to restructure its debts or sell its assets. Indeed, healthcare bankruptcies more than tripled in 2017,¹² and recent trends suggest that healthcare providers are continuing to look at bankruptcy as a means to close, consolidate, and restructure.¹³ But the bankruptcy system presents significant conflicts with healthcare policy and practice, meaning that the bankruptcy process, in practice, very often fails to meet the needs and expectations of healthcare debtors, their creditors, regulators, and patients. As a consequence, many

⁹ See, e.g., ARIZ. REV. STAT. ANN. § 36-401(21) (2017). The statute defines a “health care institution” as

[E]very place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, behavioral health services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies . . . outdoor behavioral health care programs and hospice service agencies.

Id.

¹⁰ See, e.g., Jack Healy, *It’s 4 A.M. The Baby’s Coming. But the Hospital Is 100 Miles Away.*, N.Y. TIMES (July 17, 2017), <https://www.nytimes.com/2018/07/17/us/hospital-closing-missouri-pregnant.html> [<https://perma.cc/Z225-TDPN>] (describing problems stemming from lack of obstetric services, including delivery of babies outside of the hospital setting and more premature births).

¹¹ Lawrence K. Altman, *Study Finds Widespread Problem of Inadequate Health Care*, N.Y. TIMES (May 5, 2004), <https://www.nytimes.com/2004/05/05/us/study-finds-widespread-problem-of-inadequate-health-care.html> [<https://perma.cc/K98G-CG5Z>].

¹² Ayla Ellison, *Healthcare Bankruptcies More Than Triple in 2017*, BECKER’S HOSP. CFO REP. (Nov. 28, 2017), <https://www.beckershospitalreview.com/finance/healthcare-bankruptcies-more-than-triple-in-2017.html> [<https://perma.cc/AQW6-5ECZ>].

¹³ David A. Samole, *Hospital Impact—A Guide to a Healthcare Provider Bankruptcy Case*, FIERCE HEALTHCARE (July 13, 2017), <https://www.fiercehealthcare.com/hospitals/hospital-impact-a-guide-to-a-healthcare-provider-bankruptcy-case> [<https://perma.cc/2CBV-DZZY>]; see Pamela Foohey, *Counting Healthcare Chapter 11 Filings: Are There More Than Expected?*, CREDIT SLIPS (May 23, 2019), <https://www.creditslips.org/creditslips/2019/05/counting-healthcare-chapter-11-filings-are-there-more-than-expected.html> [<https://perma.cc/GVV5-7PQ9>] (noting that, although the “data do not show a large increase in healthcare chapter 11 cases in recent years” the data “do show that hospitals, physician practices, healthcare systems, and clinics have steadily filed chapter 11 over the last decade, perhaps in greater numbers than one may have anticipated”). See generally Harvey R. Miller & Shai Y. Waisman, *Is Chapter 11 Bankrupt?*, 47 B.C. L. REV. 129 (2005) (exploring the role of chapter 11 bankruptcy in business reorganization, arguing for the need and use of chapter 11 to preserve businesses, and challenging critics of chapter 11).

healthcare institutions struggle to reorganize or even liquidate in this bankruptcy “minefield.”¹⁴

This Article argues that healthcare institutions (also referred to herein as “healthcare debtors”) are bankruptcy misfits. The goals and purposes of a healthcare institution’s bankruptcy do not mesh well with the Bankruptcy Code’s (“Code”) existing statutory framework. Specifically, state and federal regulatory policies and practices, designed to protect the public health, conflict with the bankruptcy system’s aim of maximizing the value of the business for the benefit of all creditors.¹⁵ When a healthcare institution files for bankruptcy, these public policy issues often come into play in the bankruptcy case.

Bankruptcy law often conflicts with other laws and policies.¹⁶ In the healthcare context, however, these conflicts are particularly concerning because of the healthcare system’s importance to the U.S. economy and population.¹⁷ Unlike in a traditional business bankruptcy case, a healthcare provider bankruptcy involves a distinct set of players, notably regulators and patients, whose concerns and interests may conflict with the financial goals of the debtor and its creditors.¹⁸ As this Article illustrates, these players’ attempts to address their collateral concerns interfere with the healthcare debtor’s ability to successfully navigate the bankruptcy proceeding.¹⁹

For these reasons, the legal community has long debated whether bankruptcy is an effective or necessary solution for financially distressed healthcare institutions.²⁰ These debates echo, to some extent, a larger debate about the

¹⁴ See Jonathan Edwards & Sarah Ernst, *Healthcare Providers: Financial Distress Isn’t Going Away*, BECKER’S HOSP. CFO REP. (Oct. 19, 2017), <https://www.beckershospitalreview.com/finance/healthcare-providers-financial-distress-isn-t-going-away.html> [<https://perma.cc/TXQ2-2HN2>] (“Healthcare restructurings are extraordinarily complex because they . . . require practitioners to navigate a minefield of healthcare-specific fiduciary, governmental, regulatory, and contractual issues. . . . Bellflops into healthcare bankruptcies don’t end well.”).

¹⁵ See Brian P. Stern & Christopher J. Fragomeni, *The Triage and Treatment of Healthcare Institutions in Distress: How to Involve State Regulators in Healthcare Bankruptcies and Receiverships*, 22 ROGER WILLIAMS U.L. REV. 147, 147–48 (2017) (“Financially distressed healthcare institutions pose unique and complex public policy concerns when the goals of an insolvency proceeding conflict with a state’s responsibility to regulate the public health through state regulatory agencies.”).

¹⁶ See Deryck A. Palmer & Michele J. Meises, *Collision Course Between Bankruptcy and Health Care Laws: Which Will Ultimately Control?*, 1999 NORTON ANN. SURV. BANKR. L. 1, 17–20 (describing conflicts between bankruptcy law and labor law, banking statutes, and environmental law).

¹⁷ See Reed Abelson, *Hospitals Stand to Lose Billions Under ‘Medicare for All,’* N.Y. TIMES (Apr. 21, 2019), <https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html> [<https://perma.cc/TC3V-M9E2>] (noting that “the health care industry . . . makes up 18 percent of the nation’s economy and is one of the nation’s largest employers”).

¹⁸ See Stern & Fragomeni, *supra* note 15, at 148.

¹⁹ See *infra* Part II and notes 79–190.

²⁰ See generally Samuel Maizel et al., *The Healthcare Industry Post-Affordable Care Act: A Bankruptcy Perspective*, 31 EMORY BANKR. DEV. J. 249 (2015) (discussing problems with hospital bankruptcies); Vinay Chopra, Comment, *Too Late for a Fresh Start: Why the Bankruptcy Code*

appropriate role of bankruptcy as a means to resolve the financial distress of other important debtors, such as financial institutions²¹ and government entities.²² These debates also reflect bankruptcy's ability to address certain situations, such as derivative contract defaults²³ and problems with cryptocurrencies.²⁴ Using healthcare institutions as a lens, this Article sheds new light on these debates by examining the extent to which they reflect underlying concerns with the structure and design of the Bankruptcy Code itself.

Despite the difficulties inherent in healthcare provider bankruptcy cases, this Article concludes that bankruptcy can still serve as a practical and valuable remedy for healthcare debtors. In order for healthcare institutions to “fail better,” however, the competing powers and priorities of the various players must be organized, balanced, and accommodated within the bankruptcy context. Unfortunately, neither healthcare policy nor the Bankruptcy Code's current

Should Exclude Continuing Care Retirement Communities, 27 EMORY BANKR. DEV. J. 71 (2010) (arguing that the Bankruptcy Code is inappropriate for addressing problems faced by continuing care retirement communities); Nancy A. Peterman et al., *Bankruptcy Restructuring of Healthcare Entities*, AM. BAR ASS'N (May 16, 2017), https://www.americanbar.org/content/dam/aba/administrative/health_law/Bankruptcy_5_16_17.authcheckdam.pdf [<https://perma.cc/BQ94-LUK9>] (suggesting that receivership is a better option than bankruptcy for healthcare entities).

²¹ See generally Thomas H. Jackson, *Bankruptcy Code Chapter 14: A Proposal*, in BANKRUPTCY NOT BAILOUT 25 (Kenneth E. Scott & John B. Taylor eds., 2012) (proposing a new chapter 14 of the Bankruptcy Code, which would provide financial institutions with Code-based bankruptcy relief); Adam J. Levitin, *Bankruptcy's Lorelei: The Dangerous Allure of Financial Institution Bankruptcy*, 97 N.C. L. REV. 243 (2019) (arguing against bankruptcy for financial institutions); David A. Skeel, Jr., *Bankruptcy for Banks: A Tribute (and Little Plea) to Jay Westbrook*, FAC. SCHOLARSHIP PENN L. (2018), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3013&context=faculty_scholarship [<https://perma.cc/RQT4-5F8T>] (supporting proposed legislation for bank bankruptcies but noting that bankruptcy for banks “is more controversial among bankruptcy scholars”); Mark Roe, *Don't Bank on Bankruptcy for Banks*, PROJECT SYNDICATE (Oct. 18, 2017), <https://www.project-syndicate.org/commentary/bank-bankruptcy-regulations-by-mark-roe-2017-10?barrier=accesspaylog> [<https://perma.cc/9GXW-95V8>] (discussing problems with mega-bank bankruptcies).

²² See, e.g., John A.E. Pottow, *What Bankruptcy Law Can and Cannot Do for Puerto Rico*, 85 REV. JUR. U.P.R. 689, 689–704 (2016) (analyzing the benefits and limitations of bankruptcy for restructuring the debt of Puerto Rico and its municipalities). See generally Laura N. Coordes, *Restructuring Municipal Bankruptcy*, 2016 UTAH L. REV. 307 (discussing problems with and reforms to chapter 9 of the Bankruptcy Code for the purpose of restructuring municipal debt).

²³ See generally Jay L. Westbrook, *Sovereign Debt and Exclusions from Insolvency Proceedings*, in A DEBT RESTRUCTURING MECHANISM FOR SOVEREIGNS 251 (Christopher G. Paulus ed., 2014) (arguing that “[t]he systemic risks created by derivatives . . . cry out for . . . their inclusion in bankruptcy proceedings”).

²⁴ See, e.g., Erin Jane Illman & Robert A. Cox, Jr., *Bitcoin and Bankruptcy: Why Creditors and Bankruptcy Practitioners Need to Understand Cryptocurrencies*, BRADLEY (Dec. 14, 2017), <https://www.bradley.com/insights/publications/2017/12/bitcoin-and-bankruptcy-why-creditors-and-bankruptcy-practitioners-need> [<https://perma.cc/TU4M-GYWM>] (noting that bitcoin is likely to “show up as an ‘asset’ of the debtor in a bankruptcy case” and that “the value and use of such bitcoin may play an important role in the debtor's bankruptcy case”).

structure gives courts (and the affected regulators, debtors, patients, and creditors) this necessary guidance.

To better align the bankruptcy system and healthcare goals, this Article proposes that healthcare institutions' bankruptcies be addressed through separate subchapters of the Bankruptcy Code. As this Article demonstrates, prior piecemeal attempts to make the Code more responsive to competing interests in the healthcare context have been largely unsuccessful. For this reason, this Article posits that bankruptcy law needs a structural adjustment to more fully recognize and account for the variety of players in a healthcare institution's bankruptcy and their competing concerns and interests.

This Article proceeds in five Parts. Part I introduces the healthcare industry and describes both its significance to the U.S. economy and its tendency toward financial vulnerability.²⁵ Part II discusses the particular problems healthcare debtors face in bankruptcy proceedings.²⁶ Although the problems are numerous, they can be grouped into two distinct categories. First, the Code is insufficiently specific with respect to healthcare issues. And second, the Code lacks a way to organize and prioritize the competing interests of the various players in a healthcare bankruptcy case. Part III demonstrates how existing reforms and alternatives to bankruptcy have fallen short of providing healthcare debtors the relief they need.²⁷ Part IV explores whether and how healthcare provider bankruptcy cases should fit within the Code's structure and offers two proposals for making bankruptcy more workable for healthcare debtors: (i) further, targeted amendments to the Code, and (ii) the addition of subchapters within the Code specifically for healthcare business debtors.²⁸ Part V concludes by situating the plight of healthcare institutions within the broader debate about the design of the Code and how it can or should accommodate the needs of a growing and diverse set of debtors, creditors, and interested parties.²⁹

I. HEALTHCARE'S SIGNIFICANCE AND VULNERABILITY

The "healthcare industry" or "healthcare sector" is a dynamic field that constitutes a significant portion of the U.S. economy. Broadly speaking, the industry consists of companies that play three primary roles.³⁰ Companies that "provide medical services . . . or otherwise facilitate the provision of healthcare to patients," including hospitals, nursing homes, and skilled nursing

²⁵ See *infra* notes 30–78 and accompanying text.

²⁶ See *infra* notes 79–190 and accompanying text.

²⁷ See *infra* notes 191–247 and accompanying text.

²⁸ See *infra* notes 248–323 and accompanying text.

²⁹ See *infra* notes 324–329 and accompanying text.

³⁰ See Jim Chappelow, *Healthcare Sector*, INVESTOPEDIA (July 7, 2019), https://www.investopedia.com/terms/h/health_care_sector.asp [<https://perma.cc/43JM-DXXH>].

facilities, comprise a large and visible portion of the healthcare sector.³¹ Companies that manufacture drugs and medical equipment are the industry's second component, while insurance companies constitute the third component.³²

The various companies that make up the healthcare sector are not treated equally in bankruptcy. Notably, the Code prohibits a "domestic insurance company" from filing for bankruptcy.³³ In addition, the Code has some specialized provisions for "healthcare businesses," defined as businesses that, in essence, provide for or facilitate the provision of healthcare services.³⁴ For this Article's purposes, a "healthcare institution" or "healthcare debtor" is a business that falls within the Code's current definition of a "healthcare business."³⁵ Thus, this Article is primarily focused on providers, broadly defined, that make up the first component of the industry.

Healthcare spending represents a sizeable chunk of the U.S. economy. In 2018, U.S. healthcare spending reached \$3.6 trillion, up 4.6% from the previous year.³⁶ This amount represents \$11,172 spent on healthcare per person in the United States.³⁷ Despite the United States spending the most on healthcare globally, it is an inefficient spender because patients frequently attain suboptimal health outcomes.³⁸ The federal government is the primary purchaser of healthcare in the United States and many hospitals are reliant on Medicare revenue.³⁹

³¹ *Id.*

³² *Id.*

³³ 11 U.S.C. § 109(b)(2) (2018).

³⁴ See 11 U.S.C. § 101(27A) (2018) (defining the term "health care business" as "any public or private entity . . . that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and . . . includes [any of a number of healthcare institutions and long-term care facilities]"). In practice, the Code's definition has sometimes been read to be limited to healthcare businesses that house and feed patients. See, e.g., *In re Med. Assocs. of Pinellas, L.L.C.*, 360 B.R. 356, 361 (Bankr. M.D. Fla. 2007) (noting that the examples in the Code's definition "appear to contemplate something more than a doctor's office"); *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 905 (Bankr. D. Nev. 2006) ("[T]he type[s] of health care businesses that were the primary targets of the definition were businesses that had some form of direct and ongoing contact with patients to the point of providing them shelter and sustenance in addition to medical treatment.").

³⁵ See 11 U.S.C. § 101(27A).

³⁶ *National Health Expenditures 2018 Highlights*, CTR. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/files/document/highlights.pdf> [<https://perma.cc/Q8MF-G7R3>].

³⁷ *Id.*

³⁸ Melissa Etehad & Kyle Kim, *The U.S. Spends More on Healthcare Than Any Other Country—But Not with Better Health Outcomes*, L.A. TIMES (July 18, 2017), <http://www.latimes.com/nation/la-na-healthcare-comparison-20170715-htmstory.html> [<https://perma.cc/E2PU-FJD3>].

³⁹ See Matthew Adam Bruckner, *Higher Ed "Do Not Resuscitate" Orders*, 106 KY. L.J. 223, 253 (2017) (referencing "one survey finding that the median hospital received nearly forty-four percent of its patient revenue from Medicaid alone"); Am. Bankr. Inst., *The Healthcare Industry Bankruptcy Workouts Forum*, 8 AM. BANKR. INST. L. REV. 5, 38 (2000) [hereinafter *Workouts Forum*]; *Program Chairs Discuss Future Health Care Distress and Opportunities on Latest ABI Podcast-Ep. 222*, AM.

The healthcare industry is also a field subject to near-constant change. In recent years especially, both for-profit and non-profit healthcare models have faced unprecedented challenges. At the same time, the industry's size and relative complexity can make necessary innovation difficult for healthcare institutions.⁴⁰ As a result, new players have threatened to enter the industry to overcome such inefficiencies, including Amazon, Berkshire Hathaway, and JPMorgan Chase, who announced in January 2018 that they planned to form an independent healthcare company for their U.S. employees.⁴¹ In addition, previously distinct healthcare fields are coming together.⁴² An example of this is CVS Health's 2017 deal to purchase health insurer Aetna that created an entity that both insures and provides healthcare.⁴³

In part due to this volatility, the healthcare field is highly susceptible to financial distress.⁴⁴ In 2017, hospital profit margins sank to their lowest levels since implementation of the Patient Protection and Affordable Care Act (ACA) in 2010.⁴⁵ Rural hospitals routinely fare the worst: at least eighty-five, or roughly five percent of the country's total, have closed since 2010, leaving fewer than half of the rural counties in the United States with a hospital that

BANKR. INST. (Nov. 5, 2018), <https://www.abi.org/podcasts/program-chairs-discuss-future-health-care-distress-and-opportunities-ep-222> [<https://perma.cc/W4AH-2WY7>] [hereinafter *ABI Podcast*] (noting that the government is the biggest customer for many healthcare providers).

⁴⁰ See *How We Can Expect the Healthcare Industry to Change in the Future*, GEO. WASH. U. SCH. BUS., <https://healthcaremba.gwu.edu/blog/how-we-can-expect-the-healthcare-industry-to-change-in-the-future/> [<https://perma.cc/D7V2-ZDBU>] [hereinafter *Healthcare Industry to Change*] (“The United States has what is arguably the most complex healthcare system in the world. As a result, changes within the industry are slow.”).

⁴¹ Nick Wingfield et al., *Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care*, N.Y. TIMES (Jan. 30, 2018), <https://www.nytimes.com/2018/01/30/technology/amazon-berkshire-hathaway-jpmorgan-health-care.html> [<https://perma.cc/JPE7-BXFA>].

⁴² See *id.* (“[T]he lines between traditionally distinct areas, such as pharmacies, insurers and providers, are increasingly blurry.”).

⁴³ See Julia Belluz, *CrossFit Is Amassing an Army of Doctors Trying to Disrupt Health Care*, VOX (Dec. 13, 2018), <https://www.vox.com/science-and-health/2018/12/13/18095546/crossfit-greg-glassman-doctors-health-care-prevention> [<https://perma.cc/LUA4-9U9F>] (noting that the founder of CrossFit, an exercise program, wants it to be “a substitute for, or an extension of, health care in America”); Wingfield et al., *supra* note 41 (discussing the possibility that Amazon may enter the pharmacy business).

⁴⁴ See RICHARD T. ARROWSMITH ET AL., 2019 MIDWESTERN BANKR. INST., KEEPING THE PATIENT ALIVE: AVOIDING ADMINISTRATIVE INSOLVENCY IN HEALTH CARE CASES 63 (2019) (noting that “Medicare Part A [is] projected to be insolvent by 2026”).

⁴⁵ See *Fiscal Trends in Hospital Systems: Hospital Margins for 2017 Dive to Lowest Levels Since ACA Implementation*, MUNINET GUIDE, <https://muninetguide.com/infrastructure/healthcare/> [<https://perma.cc/THP9-U5KQ>] (noting that the “business” of hospitals has fallen steeply since the ACA's implementation); see also Matthew Goldstein, *\$146 Million Default by Nursing Home Chain Leaves U.S. on the Hook*, N.Y. TIMES (May 31, 2019), https://www.nytimes.com/2019/05/31/business/nursing-homes-mortgage-hud.html?mc_cid=73f2347f3e&mc_eid=fe8c5cf9a6 [<https://perma.cc/3ANE-P2LN>] (“The nursing home industry is increasingly being run by for-profit operators facing dwindling margins.”).

offers obstetric care.⁴⁶ Private, rural hospitals are increasingly treating patients who cannot pay their bills, in part because of the growing popularity of high-deductible health plans.⁴⁷ Recently, hospitals have experienced “[c]uts to public health-insurance programs, struggles with debt and sharply worsening finances.”⁴⁸ The strongest effects are occurring in states that have not expanded Medicaid.⁴⁹ Continuing uncertainty about the ACA and its long-term viability, increased competition, a growing need to invest in additional personnel and technology, erosion of profitability due to changing payment models, liquidity problems, operational changes, higher pharmaceutical costs, and rising wages have all been documented as contributing factors to the expected increase in the volume of healthcare provider bankruptcies.⁵⁰ In addition, although bankruptcy filings among all sectors declined by fifty-eight percent after 2010, bankruptcy activity in the healthcare sector has increased by 123% during the same time period.⁵¹

Often, healthcare institutions that serve the neediest—rural populations and the urban poor—are at the highest risk of closing.⁵² Indeed, “[i]n every decade since the 1930s, the U.S. has lost between eleven to twenty percent of its urban hospitals.”⁵³ One study found that of the more than twenty hospital bankruptcies since 2016, nearly three-quarters operated in rural areas.⁵⁴ Thus, hospitals are struggling—and closing—in the communities that are arguably the least equipped to save them.

As hospitals spend more to care for their patients, changes to Medicare reimbursements, changes imposed by the ACA, and cuts to Medicaid due to state budget constraints have made it harder for hospitals to maintain financial health.⁵⁵ At the same time, many healthcare provider systems “have significant amounts of long-term debt.”⁵⁶

⁴⁶ Healy, *supra* note 10.

⁴⁷ John Gregory, ‘Wave’ of Healthcare Bankruptcies Predicted for 2018, HEALTHEXEC (Nov. 28, 2017), <https://www.healthexec.com/topics/finance/wave-healthcare-bankruptcies-predicted-2018> [<https://perma.cc/XK92-Q77H>].

⁴⁸ Healy, *supra* note 10.

⁴⁹ *See id.*

⁵⁰ *See* Bruckner, *supra* note 39, at 231 (“[M]andates to implement expensive new technologies, rising drug costs, and declining state and federal support have caused financial strain in the [health-care] sector.”); Douglas, *supra* note 7.

⁵¹ Gregory, *supra* note 47.

⁵² Bruckner, *supra* note 39, at 238–39.

⁵³ *Id.* at 238.

⁵⁴ Press Release, Polsinelli, Hospital Bankruptcy Filings Influence Health Care Industry Distress in Q3 (Oct. 30, 2018), <https://www.polsinelli.com/newsevents/news-q3-distress-indices> [<https://perma.cc/8DRK-GU29>].

⁵⁵ ARROWSMITH ET AL., *supra* note 44, at 65 (observing that some sectors have experienced “flat to decreasing reimbursement”); Bruckner, *supra* note 39, at 239–40.

⁵⁶ Bruckner, *supra* note 39, at 241.

Even the country's largest and most established healthcare facilities have not been immune from fiscal difficulties. In 2016, several of these institutions lost hundreds of millions of dollars.⁵⁷ Partners HealthCare (New England's largest hospital network), the Cleveland Clinic, and MD Anderson (the largest cancer center in the country) all saw significant declines in their operating income.⁵⁸ Brigham & Women's Hospital, the country's second-largest research hospital and a member of Partners HealthCare, laid off almost ten percent of its workforce in 2017 due to reduced service reimbursements from insurance providers and high capital and labor costs.⁵⁹ Similarly, increased expenses, salaries, and wages led MD Anderson to reduce its workforce by five percent in 2017, after the institution's adjusted gross income dropped by seventy-seven percent in the prior fiscal year.⁶⁰ For its part, CMS recently cut \$1.6 billion from some drug payments and reduced reimbursements for off-campus hospital outpatient departments.⁶¹ These reductions will undoubtedly put further strain on healthcare institutions because they must use fewer monetary resources to treat patients who are increasingly "older" and "sicker."⁶²

Nearly any industry facing financial distress produces negative externalities. For example, factory closures relating to the financial distress of the auto industry can in turn affect the financial health of a city or town reliant on that industry for jobs.⁶³ The healthcare industry is no different in this respect.⁶⁴ The negative externalities produced by a healthcare institution's financial distress, however, can have particularly devastating consequences because individuals rely on healthcare services to survive.⁶⁵ For example, a lack of obstetric ser-

⁵⁷ Pearl, *supra* note 8.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*; see Alicia Tuovila, *Adjusted Gross Income (AGI)*, INVESTOPEDIA (Sept. 30, 2019), <https://www.investopedia.com/terms/a/agi.asp> [<https://perma.cc/KZY9-37XF>] (explaining that adjusted gross income is calculated by subtracting certain deductions and payments from a taxable entity's gross income).

⁶¹ Pearl, *supra* note 8.

⁶² *Id.*

⁶³ See, e.g., Associated Press, *Detroit in Bankruptcy: How Did It Happen?*, CRAIN'S DETROIT BUS. (July 19, 2013), <https://www.crainsdetroit.com/article/20130719/NEWS01/130719781/detroit-in-bankruptcy-how-did-it-happen> [<https://perma.cc/6EFE-VFKE>] (noting that the fall of the auto industry was "a big factor" in Detroit's financial distress).

⁶⁴ See Tiffany Kary, *Next U.S. Restructuring Epidemic: Sick Health-Care Companies*, BLOOMBERG (Nov. 27, 2017), <https://www.bloomberg.com/news/articles/2017-11-27/next-u-s-restructuring-epidemic-sick-health-care-companies> [<https://perma.cc/RXR3-E8RC>] ("Distress among health-care companies can spread to other parts of the economy.").

⁶⁵ See generally Barbara Feder Ostrov & Lauren Weber, *The Collapse of a Hospital Empire—and Towns Left in the Wreckage*, KAISER HEALTH NEWS (Aug. 20, 2019), <https://khn.org/news/rural-hospital-empire-collapse-missouri-town-fallout-jorge-a-perez-empowerhms/> [<https://perma.cc/FFN5-9Z88>] (describing the difficulties small communities have faced when local hospitals experience financial distress and bankruptcy).

vices due to the provider's financial distress or to hospital closures has been linked to a rise in premature births.⁶⁶ Studies also show that when women with inadequate obstetric care go into labor, they are more likely to deliver in emergency rooms or outside of the hospital entirely.⁶⁷ On a larger scale, a struggling healthcare system can negatively impact the country's economy. Populations that lack the means to effectively address illness and injury in turn lack a reliable workforce to generate a strong economy.⁶⁸

When a healthcare institution files for bankruptcy, it faces different challenges from those of other business-debtors due to the complexity of the policy issues affecting the institution and the extensive regulatory environment in which it operates. "The health care sector is one of the largest and most complex in the U.S. economy," and it is frequently characterized as the most complex in the world.⁶⁹ A healthcare company's business model differs from many other companies in part because of healthcare's payment model where the person receiving care (the patient) is typically not the one paying for it (a private or government insurer).⁷⁰

Due in part to extensive regulations at both the state and federal levels,⁷¹ the "operations of a health care provider are vastly different from a typical business."⁷² At the federal level, multiple agencies directly oversee the healthcare system, including the Department of Health and Human Services, the Centers for Disease Control, CMS, the Veterans Administration, the Food and Drug Administration, and the Agency for Healthcare Research and Quality.⁷³ In addition to federal regulators, state governments issue licenses to healthcare facilities and regulate the quality of care that these facilities provide.⁷⁴ In the healthcare industry, steep compliance costs accompany heavy regulation; healthcare providers who fail to rigorously follow regulations can incur "significant fines and penalties."⁷⁵

⁶⁶ Healy, *supra* note 10.

⁶⁷ *Id.*

⁶⁸ See Kevin Lee-Simion, *Healthcare: Its Influence and Importance in the Economy*, ASS'NMBAS (June 6, 2017), <https://community.mbaworld.com/blog/b/weblog/posts/healthcare-its-influence-and-importance-in-the-economy> [<https://perma.cc/J68V-CYCS>].

⁶⁹ *Healthcare Industry to Change*, *supra* note 40.

⁷⁰ Paul K. Ferdinands & Jeffrey R. Dutson, *Issues Arising in Connection with Sales of Health Care Companies*, AM. BANKR. INST. J., June 2016, at 30.

⁷¹ See Palmer & Meises, *supra* note 16, at 17.

⁷² *Id.* at 23.

⁷³ *Healthcare Industry to Change*, *supra* note 40.

⁷⁴ See generally Palmer & Meises, *supra* note 16.

⁷⁵ Ferdinands & Dutson, *supra* note 70, at 30; see, e.g., *In re Sun Healthcare Group*, No. 99-3657, 2002 WL 2018868, at *2 (D. Del. Sept. 4, 2002) (noting that a debtor's healthcare facility failed to comply with certain regulations, was terminated from Medicare and Medicaid programs, fined over \$60,000, and assessed over \$133,000 in related overpayments).

The regulatory environment is also subject to frequent change and instability. For example, after the ACA was passed in 2010, more regulatory agencies came into the picture, including the Center for Medicare and Medicaid Innovation and state insurance exchanges.⁷⁶ An October 2017 report issued by the American Hospital Association found that health systems, including hospitals, must comply with 629 regulatory requirements promulgated by four federal agencies alone.⁷⁷ The report also found that “the timing and pace of regulatory change make compliance challenging” and characterized the environment surrounding these systems as “regulatory overload.”⁷⁸ The complex and changing healthcare regulatory environment means that the parties with a vested interest in the outcome of a healthcare provider bankruptcy case are numerous and varied. As each regulator is responsible for particular aspects of a healthcare institution’s operation, regulatory goals may conflict with one another and with the goals of the bankruptcy process.

The complexity of the healthcare industry, the impact of the healthcare system’s financial distress on the broader community, and the intricate and changing regulatory environment all combine to make healthcare provider bankruptcies distinctly challenging. As Part II illustrates, the Code has proven difficult to use when financially distressed healthcare institutions bring these challenges to bankruptcy.

II. HEALTHCARE DEBTORS AS BANKRUPTCY MISFITS

This Part outlines the challenges healthcare institutions face when using the bankruptcy system.⁷⁹ Bankruptcy can be a complicated process for healthcare institutions, and many healthcare debtors may find that the difficulties of navigating the system outweigh bankruptcy’s benefits.

Healthcare businesses have several options for bankruptcy. Like all eligible debtors, they may choose to liquidate their assets under chapter 7 of the Code,⁸⁰ or they may use chapter 11’s provisions to either reorganize their debts or engage in a structured sale of the business.⁸¹ Healthcare institutions that are run by or are part of local governments, such as public hospitals, must use

⁷⁶ See ARROWSMITH ET AL., *supra* note 44, at 65 (describing an “increased regulatory burden” throughout the healthcare sector); *Healthcare Industry to Change*, *supra* note 40.

⁷⁷ AM. HOSP. ASS’N, REGULATORY OVERLOAD: ASSESSING THE REGULATORY BURDEN ON HEALTH SYSTEMS, HOSPITALS AND POST-ACUTE CARE PROVIDERS 3 (2017), <https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf> [<https://perma.cc/HY62-ZETC>]. The agencies studied were CMS, the Office of Inspector General, the Office for Civil Rights, and the Office of the National Coordinator for Health Information. *Id.*

⁷⁸ *Id.*

⁷⁹ See *infra* notes 80–190 and accompanying text.

⁸⁰ See 11 U.S.C. § 109(b) (2018) (defining eligibility for chapter 7 bankruptcy).

⁸¹ See *id.* § 109(d) (defining eligibility for chapter 11 bankruptcy).

chapter 9 of the Code to adjust their debts.⁸² Some healthcare institutions seeking to use bankruptcy may face challenges with respect to their eligibility for a particular chapter of the Code.⁸³

Healthcare institutions that are also nonprofits may face additional difficulties in bankruptcy. For example, when a nonprofit entity seeks to sell or transfer assets in bankruptcy, that sale or transfer must comply with non-bankruptcy law governing nonprofit property transfers.⁸⁴ Practically speaking, this provision means that state attorneys general must approve any sale and may (and often do) insist on certain conditions before approving a transfer.⁸⁵

With respect to the healthcare industry and others, there is a significant body of literature on the challenges faced by nonprofit institutions in bankruptcy.⁸⁶ For this reason, this Article does not particularly focus on the distinct challenges of nonprofit healthcare debtors. It is nonetheless important to note that nonprofit healthcare institutions may face difficulties related to their status as nonprofits in addition to those inherent in the general healthcare bankruptcy context.⁸⁷

Healthcare businesses that file for bankruptcy face a range of challenges. These difficulties arise in part because healthcare institutions are what this Article terms “bankruptcy misfits.” The Code is insufficiently specific with respect to healthcare debtors, and the Code lacks an organizing principle that

⁸² See *id.* § 101(40) (defining “municipality” for purposes of chapter 9 eligibility as a “political subdivision or public agency or instrumentality of a [s]tate”); *id.* § 109(c) (defining eligibility for chapter 9 bankruptcy).

⁸³ See, e.g., Daniel Gill, *Mental Health Services Nonprofit Eligible for Chapter 11*, BLOOMBERG L. (Aug. 27, 2018), <https://news.bloomberglaw.com/bankruptcy-law/mental-health-services-nonprofit-eligible-for-chapter-11?context=search&index=0> [<https://perma.cc/Q7YP-NQ3H>] (describing a case where a creditor objected to a healthcare institution’s eligibility for chapter 11 bankruptcy and argued, unsuccessfully, that the institution should have been eligible only under chapter 9 of the Code).

⁸⁴ Memorandum from Gardner Carton & Douglas to Clients, *New Health Care Business Bankruptcy Code Provisions 3* (2005), <https://files.drinkerbiddle.com/Templates/media/files/publications/2005/new-healthcare-business-bankruptcy-code-provisions.pdf> [<https://perma.cc/T6HC-CCB9>] [hereinafter *Memorandum*].

⁸⁵ *Id.*

⁸⁶ See generally Pamela Foohey, *Chapter 11 Reorganization and the Fair and Equitable Standard: How the Absolute Priority Rule Applies to All Nonprofit Entities*, 86 ST. JOHN’S L. REV. 31 (2012) (discussing the Bankruptcy Code’s treatment of nonprofit entities); Harold L. Kaplan et al., *The “Charitable Trust” Doctrine: Lessons and Aftermath of Banner Health*, AM. BANKR. INST. J., May 2004 (discussing increased attorney general scrutiny of nonprofit healthcare entities in bankruptcy and other transactions); Veronique A. Urban & Ted A. Berkowitz, *Peninsula Hospital: Dissecting a Health Care Business Bankruptcy*, AM. BANKR. INST. J., Sept. 2013 (discussing the effect of an involuntary bankruptcy petition filed against nonprofit Peninsula Hospital); Kristina Wesch, *The Impact of Antitrust Regulations on Stalking-Horse Bids*, AM. BANKR. INST. J., Aug. 2014 (noting that § 7 of the Clayton Act is routinely applied in cases of nonprofit hospital mergers and acquisitions).

⁸⁷ See generally Kaplan et al., *supra* note 86 (noting that nonprofit healthcare entities have experienced significant scrutiny and interference with their transactions).

adequately addresses the needs and interests of the competing players in a healthcare bankruptcy case. As a result, healthcare debtors using the bankruptcy system face considerably more difficulties than the average business debtor. Indeed, a 2013 study found that almost two-thirds of hospitals that filed for bankruptcy closed, with only one-third completing a reorganization.⁸⁸

A. Lack of Specificity

The Code is insufficiently specific with respect to healthcare debtors. The drafters simply did not consider many of the distinct attributes of healthcare debtors when they created the Code. As a result, circuit splits, confusion, and an overall lack of clarity characterize many critical aspects of healthcare bankruptcy.

1. Bankruptcy Eligibility

As discussed in Part I, the healthcare industry is prone to change. For this reason, a comprehensive definition of “healthcare” remains elusive under the law. Although the Code contains a definition for “health care business,”⁸⁹ it is unclear whether certain newer healthcare entities are eligible to file for bankruptcy.⁹⁰

Accountable Care Organizations (ACOs) are a prominent example of healthcare institutions with an uncertain bankruptcy eligibility status. ACOs, which were created under the ACA, are legal entities (typically limited liability companies) that coordinate patient care through the formation of networks of doctors, hospitals, and skilled nursing facilities.⁹¹ Via contract, ACOs are held accountable to government and private insurers for the cost and quality of services provided to their patients.⁹² Within an ACO, a particular provider’s reimbursement for its services is conditioned on that provider meeting the specific financial and quality benchmarks defined in the ACO agreement.⁹³

⁸⁸ Tammy Worth, *Hospital Bankruptcies a Result of Trends, Not a Single Event*, HEALTHCARE FIN. (Jan. 30, 2014), <https://www.healthcarefinancenews.com/news/hospital-bankruptcies-result-trends-not-single-event> [https://perma.cc/53ES-KNSX].

⁸⁹ 11 U.S.C. § 101(27A).

⁹⁰ See *Workouts Forum*, *supra* note 39, at 43 (noting that “[c]ertain types of healthcare companies are closer to insurance companies than they are to a traditional business enterprise,” thus making them ineligible for bankruptcy).

⁹¹ Maizel et al., *supra* note 20, at 271.

⁹² Timothy M. Lupinacci, *Rising Imbalance Between Risk and Reward: Implications for ACOs*, AM. BANKR. INST. J., Feb. 2016, at 26.

⁹³ See *id.* (“A provider’s reimbursement for health care services provided under Medicare, Medicaid or an insurance policy is conditioned upon meeting certain financial and quality goals for these patients.”).

Although the question of ACO bankruptcy eligibility has yet to reach the courts, scholars and commentators have explored the question. As a coordinator of patient care, an ACO may not qualify as a “health care business” under the Code because the Code’s definition focuses on the *provision* of services.⁹⁴ Yet, ACOs also do not seem to qualify as “domestic insurance companies,” which are ineligible for bankruptcy,⁹⁵ because the structure of the commercial entities within the ACO network is more akin to a provider model than to a typical insurance company.⁹⁶ ACOs thus fall somewhere in between healthcare providers and insurance companies.

Even if a court were to find an ACO eligible to file for bankruptcy relief, the Code is incompatible with many aspects of the ACO structure. For example, if an ACO filed for bankruptcy, each provider or practice group within the ACO would still have to make decisions in its own best interest, some of which may conflict with the interests of the ACO as a whole.⁹⁷ Furthermore, the status of the practice groups within an ACO is uncertain—namely, would these groups be considered “insiders” under the Code?⁹⁸ If so, the confirmation of the ACO debtor’s bankruptcy plan could be in jeopardy, or the practice groups themselves might be subject to more litigation as a result of the bankruptcy.

There are lots of unanswered questions about how an ACO might access and fare in bankruptcy. Yet, determining ACO eligibility and compatibility with existing bankruptcy law is important because ACOs have played a prominent role in the healthcare industry since passage of the ACA. Without a workable solution for addressing their fiscal distress, these critical components of the healthcare industry may be forced to simply shut down rather than attempt to reorganize or restructure under the bankruptcy system.⁹⁹ As of 2015, eight out of over 600 ACOs around the country had already dissolved due to financial difficulties.¹⁰⁰

ACOs are just one example of how the changing nature of the healthcare industry presents difficult eligibility questions in bankruptcy. Federal law in

⁹⁴ *Id.* at 27.

⁹⁵ 11 U.S.C. § 109(b)(2).

⁹⁶ Lupinacci, *supra* note 92, at 27.

⁹⁷ *Id.* at 26.

⁹⁸ Maizel et al., *supra* note 20, at 270. The term “insider” is defined in § 101 of the Code and includes a “person in control of the debtor” and a “general partner of the debtor.” 11 U.S.C. § 101(31)(B)(iii)(v). Insiders often receive different treatment in bankruptcy. *See, e.g., id.* § 547(b)(4)(B) (providing for a one-year, rather than ninety-day, lookback period for preferential transfers involving insiders).

⁹⁹ Maizel et al., *supra* note 20, at 271–72. It is possible that ACOs could access other non-bankruptcy workout mechanisms, such as receiverships and assignments for the benefit of creditors. As Parts III and IV discuss, however, bankruptcy has distinct benefits and may be necessary for healthcare providers such as ACOs in certain circumstances.

¹⁰⁰ *Id.* at 269.

general, and bankruptcy law in particular, may soon have to address another difficult question, that of the status of medical marijuana. Although marijuana remains an illegal drug at the federal level pursuant to the Controlled Substances Act,¹⁰¹ businesses that provide medical marijuana may be considered by states to be “health care businesses.” Thus far, bankruptcy courts have consistently determined that marijuana-linked “health care” businesses are ineligible for bankruptcy, although it is not clear how closely linked a business must be to one distributing marijuana for its bankruptcy petition to be dismissed.¹⁰² If the meaning of “health care” continues to evolve at the state level, it may be necessary for bankruptcy law to address the issue of whether the growing number of medical marijuana providers should be eligible for bankruptcy. Similarly, the CVS/Aetna merger discussed above raises questions about whether hybrid “insurer-provider” entities will be eligible for bankruptcy, should they need it, because the new company intertwines provisions of healthcare services with insurance. As new business structures and organizations enter the healthcare field, it will be critical to establish processes for these entities when they undergo financial distress. Without a clear understanding of how debt can be restructured, creditors may hesitate to lend to these healthcare institutions. A healthcare entity with questionable bankruptcy eligibility status may have no choice but to shut down if bankruptcy relief is ultimately denied. Thus, the Code’s definition of a “health care business” may soon need an update.

2. Provider Agreements and Quality Assurance Fees

The majority of healthcare businesses do not face eligibility hurdles when seeking to file for bankruptcy. But in many instances, the Code and rules make it difficult for healthcare debtors to achieve their desired outcomes in bankruptcy.

One prominent example of the way in which the design of the Code presents difficulties for healthcare debtors relates to the Code’s unclear treatment of provider agreements. A provider agreement is a contract between a healthcare professional and an organization or healthcare plan that governs the

¹⁰¹ 21 U.S.C. § 811 (2018).

¹⁰² See Steven J. Boyajian, *Just Say No to Drugs? Creditors Not Getting a Fair Shake When Marijuana-Related Cases Are Dismissed*, AM. BANKR. INST. J., Sept. 2017, at 24 (noting that “marijuana assets may not legally be administered in bankruptcy”); David McAfee, *Marijuana Industry Can’t Partake in Bankruptcy Protection*, BLOOMBERG L. (June 20, 2017), <https://news.bloomberglaw.com/bankruptcy-law/marijuana-industry-cant-partake-in-bankruptcy-protection?context=search&index=0> [<https://perma.cc/7L2B-NZ5K>]; Bill Rochelle, *Ninth Circuit BAP Backs Away from Automatic Dismissal of “Marijuana” Cases*, AM. BANKR. INST. (Feb. 27, 2018) (describing a case where the court held that bankruptcies should not be dismissed simply because of marijuana on the premises of the business).

relationship between the parties.¹⁰³ Importantly, any healthcare business receiving payments from Medicare or Medicaid must have a provider agreement.¹⁰⁴ Providers are reimbursed under these agreements, but the reimbursement system used by the federal government often results in the government overpaying the provider.¹⁰⁵ The provider then owes the government for repayment of any overpayments.

When a healthcare provider files for bankruptcy, it may try to sell its business free and clear of liabilities.¹⁰⁶ Provider agreements are valuable assets included in these sales because they allow the provider to be repaid from a private or government insurer. Unfortunately, the Code does not specify how these valuable agreements should be treated in bankruptcy. In the courts, there is a split of authority over whether provider agreements constitute executory contracts or estate assets.¹⁰⁷ If a court deems a provider agreement to be an estate asset, the debtor may sell the agreement free and clear of liabilities, including overpayments, in bankruptcy.¹⁰⁸

On the other hand, if a court deems a provider agreement to be an executory contract, one where substantial obligations are outstanding on both sides, the Code requires the debtor to “cure” the agreement in the form of repaying any liabilities before the debtor can sell it.¹⁰⁹ Providers may have received significant overpayments from the federal government, making it very expensive for the already cash-strapped debtor to cure the agreement in time to sell it.¹¹⁰ From the debtor’s standpoint, it may be desirable for provider agreements to be classified as estate assets in bankruptcy so that they may be sold free and clear of any overpayment liability.¹¹¹ Such treatment can result in significant savings for the debtor and may even make the difference between whether the debtor can proceed with a sale or be forced out of bankruptcy.¹¹² In contrast, regula-

¹⁰³ Ferdinands & Dutson, *supra* note 70, at 30.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 31.

¹⁰⁶ Douglas, *supra* note 7.

¹⁰⁷ *See id.* (citing the following compared cases); compare *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008) (holding that a provider agreement is an executory contract), with *In re BDK Health Mgmt., Inc.*, No. 98-00609, 1998 WL 34188241, at *6 (Bankr. M.D. Fla. Nov. 16, 1998) (holding that a provider agreement is a statutory entitlement).

¹⁰⁸ Douglas, *supra* note 7.

¹⁰⁹ 11 U.S.C. § 365.

¹¹⁰ Douglas, *supra* note 7.

¹¹¹ *Id.*

¹¹² *Id.*

tors have argued that these agreements should be considered executory contracts that the debtor must quickly assume (and cure).¹¹³

Only a few decisions have addressed whether provider agreements are executory contracts or estate assets.¹¹⁴ Most courts, though not all, have concluded that provider agreements are executory contracts that must be cured before they are sold.¹¹⁵ Classifying provider agreements as executory contracts is a reasonable interpretation of the Code, which does not provide clear guidance one way or the other. Yet, the practical effect of this interpretation is often to deprive the provider of the ability to sell its business in bankruptcy. This is because many providers do not have the funds to address their liabilities and cure the agreements. For example, in *In re Vitalsigns Homecare*, the debtor's chapter 7 trustee sought to sell the debtor's Medicare provider number free and clear of encumbrances, to another entity, ABC.¹¹⁶ In response to an objection from the government that it should have the right to recoup overpayments from future Medicare payments, ABC argued, *inter alia*, that the amount of the overpayment was so high that no one would acquire the provider number with the overpayment liability attached.¹¹⁷ Thus, in order for the trustee to maximize recovery for the benefit of creditors, ABC argued that the trustee should be allowed to sell the provider number free and clear of this substantial encumbrance.¹¹⁸

Another example of a lack of clarity in the Code with respect to healthcare debtors relates to the treatment of quality assurance fees. Some states impose quality assurance fees on certain healthcare providers, such as skilled nursing facilities.¹¹⁹ These fees are collected by the state and distributed as a way to provide additional support and improvements for all similar facilities in the state.¹²⁰ It is not clear whether these fees are excise taxes, and thus entitled to

¹¹³ See *Workouts Forum*, *supra* note 39, at 44 (noting that regulatory agencies frequently have a “financial stranglehold” over healthcare debtors, such that they seek to force the debtor to assume the provider agreement “very early in the process”).

¹¹⁴ Douglas, *supra* note 7.

¹¹⁵ *Id.*; see, e.g., *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1075 n.13 (3d Cir. 1992) (holding that a Medicare provider agreement “easily” fits within the definition of an executory contract).

¹¹⁶ 396 B.R. at 234. The court explained further in its opinion that a provider number is a unique number issued by CMS to the healthcare provider in order for the provider to “submit[] claims for reimbursement of covered goods and/or services under the Medicare program.” *Id.* at 238.

¹¹⁷ *Id.* at 234.

¹¹⁸ *Id.* at 233. The court ultimately allowed the sale of the provider number free of encumbrances, but subject to the priority of HHS to recover overpayments. *Id.* at 241.

¹¹⁹ See, e.g., *Quality Assurance Fee*, CAL. DEP’T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/provgovpart/Pages/Qaf.aspx> [<https://perma.cc/9LBM-S62F>].

¹²⁰ See, e.g., *Hospital Quality Assurance Fee Program*, CAL. DEP’T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/provgovpart/Pages/HospitalQualityAssuranceFeeProgram.aspx> [<https://perma.cc/EN33-2H2S>].

special priority in bankruptcy.¹²¹ Like the aforementioned issues, the Code does not provide specific guidance and healthcare debtors are uncertain as to the priority these fees should receive with respect to other payments to creditors.

Uncertainty over how a court will classify provider agreements and quality assurance fees in bankruptcy makes the healthcare bankruptcy process unpredictable. The lack of clear guidance on these classification issues makes it difficult to place an accurate value on the debtor's bankruptcy assets, raises questions about the relative priorities of the debtor's various creditors, and leaves provider agreement counterparties uncertain of the treatment they will receive in the bankruptcy.

Bankruptcy is designed to offer an expedited forum for resolving disputes, and production of predictable outcomes for creditors is often touted as one of bankruptcy's key attributes.¹²² Given these characteristics, the uncertainty surrounding provider agreements and quality assurance fees diminishes the value of the bankruptcy process for debtors and creditors alike. Furthermore, a court's resolution of these issues can effectively determine whether bankruptcy will be a viable option for a particular healthcare debtor, making certainty in this area highly desirable in order for a prospective debtor to accurately engage in pre-bankruptcy planning.

3. Jurisdiction

One of the most significant problems in a healthcare provider bankruptcy case is the uncertainty surrounding what issues the bankruptcy court has the authority to address. In particular, there is a question of whether bankruptcy courts have jurisdiction to resolve Medicare and Medicaid disputes.¹²³

Whether a federal or state agency can terminate a healthcare debtor's Medicare or Medicaid provider agreement in bankruptcy is currently not clear. Outside of bankruptcy, "federal and state officials may terminate a provider agreement if they determine that the provider is not complying with its terms

¹²¹ Douglas, *supra* note 7; see Julia Kagan, *Excise Tax*, INVESTOPEDIA (Sept. 3, 2019), <https://www.investopedia.com/terms/e/excisetax.asp> [<https://perma.cc/DQ8G-MYDK>] ("An excise tax is a legislated tax on specific goods or services at purchase such as fuel, tobacco, and alcohol. . . . Consumers may or may not see the cost of excise taxes directly.").

¹²² Allyson Pierce, *Making the Right CHOICES for a SIFI Bankruptcy*, AM. BANKR. INST. J., Oct. 2018, at 34.

¹²³ See, e.g., Maizel et al., *supra* note 20, at 263; Press Release, Jenner & Block, Firm Files Petition for Writ of Certiorari in Supreme Court on Jurisdictional Debate Regarding Bankruptcy and Medicare (Feb. 2, 2017), <https://jenner.com/library/news/16517> [<https://perma.cc/99FH-ACDS>] (describing a cert petition filed that argues the "uncertainty surrounding [jurisdictional questions] imposes a significant burden on health care providers and their patients").

or other legal requirements.”¹²⁴ If a provider wishes to dispute the termination, the Social Security Act limits that provider’s ability to pursue such claims in federal court.¹²⁵ Specifically, before proceeding in federal court, the provider must exhaust its administrative remedies with the agency in question.¹²⁶ The backlog of administrative cases is significant, meaning that the status of a provider’s agreement could be in question for years.¹²⁷ Given the importance and value of a provider agreement, keeping the status of that agreement in limbo for years is an untenable position in the context of a bankruptcy, where prompt resolution of issues is essential.

Although bankruptcy courts are federal courts, they were excluded from the Social Security Act’s definition of a “federal court” for purposes of the exhaustion requirement.¹²⁸ It is unclear, however, whether this exclusion was intentional or a mere oversight. In bankruptcy, some healthcare providers have tried to argue that the bankruptcy court has jurisdiction to hear and resolve their dispute with the agency even if the provider has not exhausted its administrative remedies.¹²⁹ Most circuits have said that bankruptcy courts lack jurisdiction unless the provider has exhausted administrative remedies.¹³⁰ The Ninth Circuit Court of Appeals, however, has held that exhaustion of administrative remedies is not necessary for a bankruptcy court to have jurisdiction to resolve the dispute.¹³¹ But in many circuits, exhaustion of administrative remedies is necessary, making bankruptcy a weaker tool for a healthcare debtor to address its debts comprehensively.¹³²

¹²⁴ Douglas, *supra* note 7.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ Kelly Gooch, *AHA Files Brief in Medicare Appeals Backlog Case: 9 Things to Know*, BECKER’S HOSP. CFO REP. (Aug. 13, 2018), <https://www.beckershospitalreview.com/finance/aha-files-brief-in-medicare-appeals-backlog-case-9-things-to-know.html> [<https://perma.cc/X394-EDEU>].

¹²⁸ 28 U.S.C. § 1334 (2018); 42 U.S.C. § 405(h) (2018).

¹²⁹ See, e.g., Petition for Writ of Certiorari at 34–35, *Bayou Shores SNF, LLC v. Fla. Agency for Health Care Admin.*, 137 S. Ct. 2214 (2017) (No. 16-967) (arguing that “[t]he Eleventh Circuit’s decision regarding exhaustion was . . . erroneous”).

¹³⁰ Douglas, *supra* note 7 (citing cases).

¹³¹ *Id.* (citing *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010)). The Fifth Circuit Court of Appeals also recently came to the same conclusion with respect to the bankruptcy court’s jurisdiction to hear Social Security claims. See *Matter of Benjamin*, 932 F.3d 293, 298 (5th Cir. 2019).

¹³² See Jason W. Harbour & Shannon E. Daily, *First Circuit Declines to Weigh in on Bankruptcy Court Jurisdiction Over Medicare Provider Agreements*, AM. BANKR. INST. J., April 2017, at 100 (“[A] debtor may have limited remedies—or possibly no remedy at all—in bankruptcy court should CMS terminate a debtor’s provider agreement.”); see also Samuel J. Seneczko, Note, *Madness in Medicare: Bayou Casts Uncertainty Over the Future of Nursing Facility Bankruptcies*, 2019 U. ILL. L. REV. 429, 429 (discussing a split between the Ninth and Eleventh Circuits over whether bankruptcy courts have jurisdiction over Medicare and Medicaid disputes and noting that, if the court does not have jurisdiction, “the nursing facility is effectively unable to bring its case before the bankruptcy court and potentially denied an opportunity to reorganize”); Memorandum from Robert N.H. Christ-

4. The Automatic Stay and Recoupment

Government attempts to recoup or set off Medicare and Medicaid reimbursement overpayments add yet another complication to the healthcare bankruptcy process. Medicare and Medicaid use a periodic interim payment system, whereby the agency reimburses providers before making a final determination as to the reimbursed amount.¹³³ If the government agency overpays, the provider must return any overpayment.¹³⁴ If a provider files for bankruptcy before returning overpayments, courts are divided over whether bankruptcy's automatic stay prohibits the federal or state government from attempting to recover the overpayments.¹³⁵ The issue turns on whether the attempt at recovery is a "setoff" or "recoupment."

Most courts have held that a provider's participation in Medicare is a "single, integrated, and ongoing transaction," meaning that any government recovery of overpayments is classified as a recoupment, rather than a setoff of amounts from different transactions.¹³⁶ The distinction between setoff and recoupment matters because post-bankruptcy setoffs of mutual pre-bankruptcy claims arising from separate transactions are subject to the automatic stay.¹³⁷ In contrast, recoupment actions, arising from a single transaction, are said not to span pre- and post-petition claims and are thus not subject to the automatic stay.¹³⁸ Thus, if a court holds that the government's attempt at recovery is a recoupment, the government can effectively "jump the line" and get paid first, ahead of other creditors.¹³⁹

The recoupment doctrine is not uniformly applied in healthcare provider bankruptcy cases.¹⁴⁰ In *University Medical Center v. Sullivan*, the Third Circuit Court of Appeals concluded that efforts to recover prepetition overpayments from post-petition Medicare payments constituted a setoff and subjected these efforts to the automatic stay.¹⁴¹ In contrast, the First, Seventh, Ninth, and D.C.

mas to Clients of Nixon Peabody LLP, *Bayou Shores Decision Is a Reminder That, in a Fight with CMS Over Medicare/Medicaid Reimbursement, Successful Restructurings Require Advice of Experienced Health Care Counsel* (Aug. 9, 2016), https://www.nixonpeabody.com/-/media/Files/Alerts/184599_bayou_shores_decision_9AUGUST2016.ashx [<https://perma.cc/JUS5-ZEBC>].

¹³³ Douglas, *supra* note 7.

¹³⁴ *Id.*

¹³⁵ *Id.*; see 11 U.S.C. § 922 (providing the title of the statute, "Automatic stay of enforcement of claims against debtor").

¹³⁶ Douglas, *supra* note 7.

¹³⁷ *Id.*; see 11 U.S.C. § 553.

¹³⁸ Douglas, *supra* note 7.

¹³⁹ Maleaka Guice, Comment, *Government Recovery of Medicare Overpayments and the Automatic Stay*, 34 EMORY BANKR. DEV. J. 127, 163 (2017).

¹⁴⁰ Douglas, *supra* note 7.

¹⁴¹ See 973 F.2d at 1080 ("[R]eimbursement payments made for any one year arise from transactions wholly distinct from reimbursement payments made for subsequent years.").

Circuit Courts of Appeals have held that under the Medicare statute, a single transaction can include a series of many occurrences, as long as these occurrences are linked by a logical relationship.¹⁴² These circuits have therefore concluded that efforts to recover overpayments are in fact properly classified as recoupments.

Once again, conflicting precedent over the treatment of money in the healthcare provider bankruptcy context makes bankruptcy less predictable and arguably less useful for distressed healthcare businesses. When a court characterizes government recovery of overpayments as a recoupment, the bankruptcy norm of equality of distribution among creditors is undermined.¹⁴³ Furthermore, in the majority of circuits where overpayment collection efforts have been classified as recoupments, such efforts, when allowed by the bankruptcy courts, can significantly disrupt the revenue cycles of healthcare institutions and could make the difference between a successful bankruptcy outcome and the closure of the facility.¹⁴⁴ Inconsistency with respect to classification of overpayment recovery thus impacts both the relative priorities of a healthcare debtor's creditors and the valuation of such debtor's bankruptcy estate.

This Subsection has shown that many critical issues in a healthcare bankruptcy case remain unresolved from a legislative standpoint and up for debate in the courts. These issues cut to the heart of bankruptcy law: they impact bankruptcy's priority scheme, interfere with the valuation of the debtor's bankruptcy estate, and create uncertainty with respect to who can appear as a debtor and what issues can be raised in bankruptcy court.

B. Competing Players and Interests

Unfortunately, lack of clarity is not the only problem characterizing healthcare provider bankruptcy cases. There are many competing players and interests in a healthcare provider bankruptcy and bankruptcy law currently lacks a sufficient organizing principle to reconcile them. This Subsection describes the difficulties with these conflicting interests in detail.

¹⁴² Andrew H. Sherman & Boris I. Mankovetskiy, *Navigating the Choppy Waters of Health Care Insolvency Cases*, AM. BANKR. INST. J., Aug. 2018, at 15. See generally *In re Holyoke Nursing Home, Inc.*, 372 F.3d 1, 4–5 (1st Cir. 2004) (discussing the doctrine of recoupment and determination of a single transaction); *Kleven v. Household Bank F.S.B.*, 334 F.3d 638, 643 (7th Cir. 2003) (same); *In re TLC Hosps., Inc.*, 224 F.3d 1008, 1011 (9th Cir. 2000) (same); *U.S. v. Consumer Health Servs. of Am., Inc.*, 108 F.3d 390, 395 (D.C. Cir. 1997) (same).

¹⁴³ Guice, *supra* note 139, at 142; see *In re Malinowski*, 156 F.3d 131, 133 (2d Cir. 1998) (implying that recoupment should apply differently in bankruptcy cases to protect the goal of equality of distribution).

¹⁴⁴ Sherman & Mankovetskiy, *supra* note 142, at 14.

1. Regulators

The presence and influence of regulators create significant challenges in the bankruptcy of a healthcare business. Both state and federal regulators play critical roles in the healthcare industry, and their involvement does not cease when a healthcare provider files for bankruptcy.

In the healthcare context, regulators' goals frequently conflict with the purposes of bankruptcy law.¹⁴⁵ A regulator's priority is to ensure provision of adequate healthcare, while bankruptcy law aims to maximize the debtor's value for the benefit of creditors.¹⁴⁶ Observing this conflict, the district court in *In re United Healthcare System* remarked:

Unlike the sale of corporations in the private sector, [healthcare provider bankruptcy] involves the rights and obligations of the State to govern public health. The most valuable asset of the debtor, *i.e.*, its goodwill, is inextricably intertwined with the requisite . . . licenses which can only be granted by [regulators].¹⁴⁷

Thus, regulatory actions are a necessary consideration for any bankruptcy court presiding over a healthcare provider's bankruptcy case.

By virtue of their authority, regulators can exercise substantial power in a bankruptcy case.¹⁴⁸ For example, state regulators can revoke a healthcare provider's license to operate, thus forcing the debtor to cease its operations immediately.¹⁴⁹ Because approval from regulators is necessary in the sale of a healthcare business, regulators who impose conditions on a sale may increase the administrative expenses of the bankruptcy estate, making it more difficult for the debtor to emerge from bankruptcy.¹⁵⁰ In the case of nonprofits, the sale of the business is subject to "extensive" regulatory approvals.¹⁵¹ Compliance with regulatory requirements and conditions can delay or stall a sale and this delay may increase costs, either for the debtor itself or for a purchaser funding the debtor's operations prior to closing.¹⁵² Furthermore, because government money is critical to healthcare providers, both federal and state regulators can

¹⁴⁵ See *Workouts Forum*, *supra* note 39, at 43 ("Anytime you're in a highly regulated industry traditional market forces may not prevail.").

¹⁴⁶ Stern & Fragomeni, *supra* note 15, at 148.

¹⁴⁷ No. 97-1159, 1997 WL 176574, at *5 (D.N.J. Mar. 26, 1997).

¹⁴⁸ See *Workouts Forum*, *supra* note 39, at 43 ("[C]ertain regulatory agencies have powers to enforce their own regulations outside of the traditional debtor/creditor type relationship.").

¹⁴⁹ Stern & Fragomeni, *supra* note 15, at 158-59.

¹⁵⁰ *Id.* at 167-68.

¹⁵¹ Ferdinands & Dutson, *supra* note 70, at 30.

¹⁵² *Id.* at 63.

influence the amount of funds the debtor has available to pay other creditors.¹⁵³ Regulators thus may directly affect the bankruptcy estate's value, as well as the amount and timing of funds distributed to the debtor's creditors.¹⁵⁴ Finally, because of the significant role it plays in the healthcare industry, the government is often both a regulator and a creditor in a healthcare provider bankruptcy case. This raises important questions about whether and when the government should receive different treatment from other creditors.¹⁵⁵

The regulatory environment necessarily and significantly shapes a healthcare provider's bankruptcy case. Regulators, particularly at the state level, often get involved in a sale of the healthcare business in order to determine how the sale will affect the community's public health and how provision of healthcare will align with regional needs.¹⁵⁶ This state oversight process necessarily interferes with the bankruptcy process and can alter the rights of creditors and other stakeholders.¹⁵⁷ In other cases, regulators may push to keep a struggling healthcare provider open in the interests of the community, while the provider believes it is in its best financial interests to shut down.¹⁵⁸

Sometimes, the involvement of regulators can lead to power struggles, as the bankruptcy court must determine whether it has the ability to approve a sale or other plan of debt restructuring even in the absence of regulatory approval.¹⁵⁹ For example, the bankruptcy court in *In re HHH Choices Health Plan* was asked to approve the sale of the assets of a continuing care retirement community and had to determine whether state court procedures must be followed for the approval of the sale that the bankruptcy court had already found to be proper.¹⁶⁰ The bankruptcy court concluded that although other approvals might be necessary for the sale to go through, the court had the ultimate power to determine the disposition of the debtor's estate assets.¹⁶¹

¹⁵³ See *Workouts Forum*, *supra* note 39, at 12 (“[S]o much of the revenue for healthcare comes from the government, federal or state.”); see also Stern & Fragomeni, *supra* note 15, at 171 (noting that regulators commonly serve as DIP lenders in healthcare bankruptcy cases and can affect a debtor's cash flow by making capital infusions, issuing loans, or waiving licensing fees).

¹⁵⁴ Stern & Fragomeni, *supra* note 15, at 148.

¹⁵⁵ Guice, *supra* note 139, at 131.

¹⁵⁶ Sherman & Mankovetskiy, *supra* note 142, at 15.

¹⁵⁷ *Id.* (discussing specific examples of state oversight in healthcare providers' bankruptcies).

¹⁵⁸ See, e.g., Peg Brickley, *Philadelphia Struggles to Cushion the Blow from Hospital Bankruptcy*, WSJ PRO BANKR. (July 11, 2019), <https://www.wsj.com/articles/philadelphia-struggles-to-cushion-the-blow-from-hospital-bankruptcy-11562881645> [<https://perma.cc/7W4A-WBUH>] (describing how a court issued an injunction barring Hahnemann University Hospital from closing unless and until it received authorization from city authorities).

¹⁵⁹ See generally *In re HHH Choices Health Plan*, LLC, 554 B.R. 697 (Bankr. S.D.N.Y. 2016).

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 700.

In contrast, in *In re Bayou Shores SNF, LLC*, CMS sought to terminate the debtor's Medicare and Medicaid provider agreements even though the bankruptcy court had entered a plan confirmation order providing that the agreements could be assumed.¹⁶² On appeal, the Eleventh Circuit Court of Appeals found that the bankruptcy court lacked jurisdiction to review or to enjoin CMS's decision.¹⁶³

Because they may revoke licenses, hamper operations, and even shut down a healthcare business entirely,¹⁶⁴ regulators are often the key to the success or failure of a healthcare provider's bankruptcy case. It is therefore critical for courts to understand how to determine whether healthcare regulations or bankruptcy law should take precedence in any given instance.¹⁶⁵ Although at least one court has cautioned that bankruptcy courts "may not impede the State in its obligations to protect the health and safety of its citizenry,"¹⁶⁶ questions about the extent and scope of regulatory authority with respect to the bankruptcy court abound.

Some commentators have argued that regulators must play significant roles in bankruptcy.¹⁶⁷ There is evidence that coordination with state regulatory agencies in particular can assist with a successful bankruptcy.¹⁶⁸ By contrast, failure to involve regulators in a bankruptcy can detrimentally delay a case.¹⁶⁹ If a healthcare debtor seeks to close or transfer its operations, it must coordinate with all necessary regulatory bodies to ensure, for example, that any licenses are properly transferred.

But more regulator participation will not answer the question of how much authority a bankruptcy court has to override a given regulator's condi-

¹⁶² 828 F.3d 1297, 1300 (11th Cir. 2016).

¹⁶³ *Id.* at 1314–15.

¹⁶⁴ Although § 525 of the Code prohibits regulators from denying, suspending, revoking, or refusing to renew a license solely because the debtor filed for bankruptcy, courts have not approached this provision uniformly. 11 U.S.C. § 525(a). Compare *Health Care Fin. Admin. v. Sun Healthcare Grp., Inc.* (*In re Sun Healthcare Grp., Inc.*), No. 99-3657, 2002 WL 2018868, at *8 (D. Del. Sept. 4, 2002) (holding that the refusal to re-certify the terminated provider for Medicare participation violated § 525 because the refusal arose from the debtor's failure to repay dischargeable prepetition debts), with *Parkview Adventist Med. Ctr. v. United States ex rel. Dep't of Health & Human Servs.*, 842 F.3d 757, 765 (1st Cir. 2017) (holding that termination of a Medicare provider agreement did not violate § 525 because the termination arose from the debtor's voluntary termination through prepetition letter).

¹⁶⁵ Stern & Fragomeni, *supra* note 15; see Maizel et al., *supra* note 20, at 266 (describing the clash of bankruptcy with healthcare regulation as "irresistible force meets immovable object").

¹⁶⁶ *In re United Healthcare Sys., Inc.*, 1997 WL 176574, at *10.

¹⁶⁷ Stern & Fragomeni, *supra* note 15, at 209.

¹⁶⁸ See, e.g., *In re Saint Vincent's Catholic Med. Ctrs. of N.Y.*, 429 B.R. 139, 152 (Bankr. S.D.N.Y. 2010) (noting where state regulator participation allowed for a hospital's successful wind down and a satisfactory recovery for creditors).

¹⁶⁹ See, e.g., *In re Saint Michael's Med. Ctr., Inc.*, No. 15-24999 (Bankr. D.N.J. Aug. 10, 2015) (noting where lack of regulator involvement delayed disposition of estate assets).

tions.¹⁷⁰ It seems clear that the bankruptcy process was not designed merely to yield to regulators' concerns; however, regulators wield extensive power over healthcare debtors, making them a critical component of a case's success or failure.¹⁷¹ Given the often conflicting purposes of bankruptcy and healthcare regulation, power struggles between the court and regulators can significantly impact a healthcare debtor's bankruptcy case.¹⁷²

2. Patients

Another complicating factor in healthcare bankruptcies is the presence of individuals whose lives and safety may depend on the outcome of the bankruptcy case: patients. As discussed further below, certain Code amendments attempt to ensure that the needs and safety of patients are considered in a healthcare provider's bankruptcy case.¹⁷³ Nonetheless, there is a significant risk that the bankruptcy process will disrupt patients' lives and well-being, and it is not clear how much of a say, if any, patients should have in a bankruptcy case. Furthermore, statutes and regulations relating to patients, such as the Health Insurance Portability and Accountability Act (HIPAA), discussed immediately below, can interfere with the bankruptcy process.

Bankruptcy requires transparency and due process for all parties. Yet, when transparency involves patient information, the Code can conflict with the provisions of HIPAA. During a bankruptcy, parties commonly share documents in order to collect information, process creditors' claims, and tally votes on a plan of action.¹⁷⁴ In a healthcare provider bankruptcy, these documents may reveal confidential patient data and personal details.¹⁷⁵ If a patient has not

¹⁷⁰ See David Deaton et al., *Distressed Healthcare: Significant Considerations for Buyers, Sellers, and Lenders Arising from the Intersection of Healthcare and Bankruptcy Laws*, 3 J. HEALTH & LIFE SCI. L. 1, 40 (2010) (noting that case law does not directly address whether a distressed healthcare provider can transfer its state licenses and certificates of need to an acquirer without first seeking approval from the applicable state authority in the bankruptcy context and concluding that "a bankruptcy court *may* have authority under bankruptcy law to effectuate a transfer . . . without the consent of the appropriate state authority") (emphasis added).

¹⁷¹ See Jonathan C. Lipson, *The Secret Life of Priority: Corporate Reorganization After Jevic*, 93 WASH. L. REV. 631, 706 (2018) (noting that the chapter 11 process "exists in part to give all stakeholders a say in what becomes of the debtor's assets" and that this purpose is not met if chapter 11 serves only the goals of senior creditors).

¹⁷² See MAUREEN D. CARMAN & RICHARD WARNE, ENERGY & MINERAL LAW INST., SMCRA ENFORCEMENT IN BANKRUPTCY: REGULATORY POWERS REVISITED 208–09 (2005) (noting that §§ 959 and 362 of the Bankruptcy Code require debtors to comply with state laws while in bankruptcy and allow regulators to compel adherence to these laws, but that § 105 of the Bankruptcy Code also recognizes that in certain cases, the debtor may be entitled to relief from these laws).

¹⁷³ See *infra* notes 191–225 and accompanying text.

¹⁷⁴ Marcus Helt & Travis K. Vandell, *Healthy Outcomes from HIPAA and Corporate Bankruptcy*, AM. BANKR. INST. J., Dec. 2016, at 24.

¹⁷⁵ *Id.*

authorized the release of this information, such document sharing constitutes a HIPAA violation.¹⁷⁶ Although healthcare debtors can take steps to establish procedures to ensure against the inadvertent disclosure of HIPAA-protected information, doing so takes time and may possibly impede efforts to reconcile creditors' claims.¹⁷⁷ In addition, because a healthcare business's success in bankruptcy often depends on whether the debtor can move quickly through the bankruptcy process, any delay in the process itself can harm a debtor's chances of exiting bankruptcy on firmer footing.¹⁷⁸

Even if a healthcare debtor can address HIPAA concerns, some healthcare institutions provide critical services to their communities. If these healthcare providers cease operations or default on their debts such that their ongoing operation is threatened, crises can result on a larger scale.¹⁷⁹ The fact that a healthcare provider's bankruptcy can trigger a public welfare crisis may color the way the bankruptcy judge oversees and decides the case.¹⁸⁰ For example, the bankruptcy court in *In re Bayou Shores* held that the debtor, a skilled nursing facility uniquely suited to providing care to patients with acute dementia and similar problems, could assume a Medicare provider agreement and thus could continue to operate post-bankruptcy.¹⁸¹ The state regulatory agency had previously announced that it would not renew the debtor's nursing license because the debtor had failed to comply with the terms of its Medicare provider agreement.¹⁸² The bankruptcy judge, in an apparent effort to prevent the facility from closing anyway, held that there was at least a colorable argument that the facility would get its license renewed because it could assume the provider agreement.¹⁸³ Observers noted that the judge's decision may in part have been driven by his desire not to be responsible for shutting the facility down.¹⁸⁴

Another recent case illustrates the challenges of balancing the needs of the debtor, its patients, and regulators. When Hahnemann University Hospital

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ See *Workouts Forum*, *supra* note 39, at 45 (“[T]he hallmark of a successful healthcare insolvency . . . is speed.”).

¹⁷⁹ See Shlomit Azgad-Tromer, *Too Important to Fail: Bankruptcy Versus Bailout of Socially Important Non-Financial Institutions*, 7 HARV. BUS. L. REV. 159, 161 (2017).

¹⁸⁰ See, e.g., Lipson, *supra* note 171, at 705 (discussing the healthcare debtor's bankruptcy in *In re ICL Holding Co. (Lifecare)*, 802 F.3d 547 (3d Cir. 2015), and how “the exigencies of the case”—particularly the fact that the debtors operated twenty-seven long-term acute care hospitals—may have influenced the court's accommodation of a deal devised among the secured creditors and the debtors).

¹⁸¹ 525 B.R. 160, 168–69 (Bankr. M.D. Fla. 2014), *rev'd on other grounds*, 533 B.R. 337 (M.D. Fla. 2015).

¹⁸² *Id.* at 171.

¹⁸³ *Id.* at 172.

¹⁸⁴ Maizel, *supra* note 20, at 265 (“[T]he courts don't want to shut down these [hospital] facilities, and one of the factors the [*In re Bayou Shores*] court cited to was transfer trauma concerns of the patients.”).

filed for bankruptcy seeking to close down, state authorities protested due to concern that the “low-income and vulnerable” patients the hospital primarily serves would be unable to obtain adequate medical care.¹⁸⁵ State health authorities claimed that they, rather than the bankruptcy court, should oversee the hospital’s closure.¹⁸⁶ For its part, the bankruptcy court urged Hahnemann and CMS authorities to negotiate before closing down.¹⁸⁷ The competing needs and desires of patients, regulators, and the debtor have brought substantial turbulence to the bankruptcy case.¹⁸⁸ For example, out of concern that local government involvement would slow the bankruptcy case, the bankruptcy judge denied a request from local officials to be included as a consultation party during negotiations with potential bidders for the hospital’s children’s unit, saying instead that city officials should be kept informed by the hospital’s owners and could be present at the auction for the unit.¹⁸⁹

Healthcare providers face significant uncertainty when filing a bankruptcy case. The Code does not address many issues that are of specific concern to healthcare providers and that may dictate the success or failure of the provider’s bankruptcy case. Further, the courts are divided over many other issues that are critical to the progression of these cases.

¹⁸⁵ Kevin F. D’Mello, *What Philadelphia Is Losing When It Loses Hahnemann Hospital*, PHILA. INQUIRER (July 8, 2019), <https://www.phillymag.com/news/2019/07/08/hahnemann-university-hospital-closure/> [<https://perma.cc/SW7J-SN6X>]. The Pennsylvania Attorney General filed an objection to the hospital’s closure. Leslie A. Pappas, *Pennsylvania AG Opposes Closure of Historic Hahnemann Hospital*, BLOOMBERG L. (July 5, 2019), <https://news.bloomberglaw.com/bankruptcy-law/pennsylvania-ag-opposes-closure-of-historic-hahnemann-hospital> [<https://perma.cc/QHP9-NYUB>].

¹⁸⁶ See Tom Avril & Marie McCullough, *Hahnemann Announces Timeline for Shutdown; ER Closes Entirely Aug. 16*, PHILA. INQUIRER (July 16, 2019), <https://www.inquirer.com/health/hahnemann-hospital-closure-plan-20190716.html> [<https://perma.cc/7RLG-EU43>] (“City and state officials have demanded that the hospital not shut down abruptly, and the state Health Department has stationed a temporary manager at the hospital who is supposed to oversee an orderly wind-down.”).

¹⁸⁷ See Nina Feldman, *Residency Sale Stalemate Hangs up Ruling in Hahnemann Bankruptcy*, WHYY (Sept. 4, 2019), <https://whyy.org/articles/residency-sale-stalemate-hangs-up-ruling-in-hahnemann-bankruptcy/> [<https://perma.cc/982U-K9HA>] (describing how the bankruptcy judge asked a CMS representative to continue negotiating before coming back to court).

¹⁸⁸ Hahnemann’s residents represent another important interest in the bankruptcy case that conflicts with bankruptcy interests. Although a bankruptcy judge gave the hospital permission to set up an auction for its residency program, residents have argued that they are not financial assets and they should be guaranteed continued access to Medicare funds that pay their salaries, regardless of whether they stay with the company or leave. See Steven Church, *Doctor Tells Court We ‘Are Not Assets’ at Bankruptcy Hearing*, BLOOMBERG L. (July 22, 2019), <https://news.bloomberglaw.com/bankruptcy-law/doctor-tells-court-we-are-not-assets-at-bankruptcy-hearing> [<https://perma.cc/AR8C-QVEA>].

¹⁸⁹ Leslie A. Pappas, *Bankrupt Philadelphia Hospital to Auction off Children’s Unit*, BLOOMBERG L. (July 26, 2019), <https://news.bloomberglaw.com/bankruptcy-law/bankrupt-philadelphia-hospital-to-auction-off-childrens-unit> [<https://perma.cc/S4FX-PS4X>].

In addition, there are distinct competing interests in a healthcare bankruptcy that are simply not present in other business bankruptcies.¹⁹⁰ In particular, it is important for courts to know how to account for and reconcile the goals and needs of patients and regulators relative to the goals of bankruptcy law more generally. Lack of guidance regarding how to balance the concerns of the debtor, its creditors, and its regulators may result in power struggles between regulators and the bankruptcy court. The bankruptcy system, by and large, has failed to manage these competing interests in a predictable way, creating uncertainty for the courts as to how to maximize the debtor's value without disrupting patient care. As discussed further below, attempts to address some of the challenges of a healthcare provider bankruptcy case have raised new concerns involving bankruptcy's ability to provide a predictable process for healthcare debtors.

III. ADDRESSING THE CHALLENGES

Scholars and policymakers have not been ignorant of the difficulties healthcare businesses face in bankruptcy and have responded to these challenges in two primary ways. First, Congress sought to better harmonize bankruptcy law with healthcare debtors' needs when it enacted the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA). Unfortunately, these piecemeal reforms have had precisely the opposite result, introducing further complications to healthcare bankruptcies. Consequently, some commentators have argued for a second option: steering healthcare businesses away from bankruptcy entirely and toward alternative solutions, namely state receiverships. State receiverships, however, while appropriate in some instances, are not an adequate substitute for bankruptcy relief in all situations.

A. BAPCPA

BAPCPA introduced an extensive set of revisions to the Code with the aim of enacting significant reforms across many areas of bankruptcy law and practice. With respect to the bankruptcy cases of healthcare providers, however, BAPCPA's changes have often raised more issues than they have resolved.¹⁹¹

In an attempt to recognize that healthcare debtors sometimes require special treatment in bankruptcy, BAPCPA added specific definitions to the Code

¹⁹⁰ See *Workouts Forum*, *supra* note 39, at 33 (noting the "social aspect" of healthcare provider bankruptcies).

¹⁹¹ See Harold L. Kaplan, *BAPCPA: Health Care Lenders Beware?*, AM. BANKR. INST. J., Dec.–Jan. 2005, at 32 (noting that BAPCPA's changes may have a "significant effect" on healthcare providers, their lenders, and unsecured creditors and discussing complications arising from specific provisions).

pertaining to healthcare businesses. Notably, BAPCPA introduced the defined term “health care business” to the Code. A “health care business” is a public or private entity that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of injury, deformity, or disease and (ii) surgical, drug treatment, psychiatric, or obstetric care.¹⁹²

With BAPCPA, Congress also sought to recognize the importance of protecting patients’ lives and information in a healthcare provider bankruptcy case. BAPCPA added definitions for a “patient”¹⁹³ and “patient records”¹⁹⁴ to the Code. Congress also sought to have the Code acknowledge the strict confidentiality and disclosure requirements that patient records are subject to at both the federal and state levels.¹⁹⁵ In this respect, BAPCPA amended the Code to provide detailed requirements for the disposal of patient records in the event that the debtor or bankruptcy trustee cannot afford to pay for the adequate, secure storage of these records.¹⁹⁶

BAPCPA also added provisions to the Code relating to the transfer of patients in the event that a healthcare facility debtor is closing down.¹⁹⁷ Specifically, a debtor or bankruptcy trustee must use all “reasonable and best efforts” to transfer patients to a healthcare business that (i) is in the vicinity of the healthcare business that is closing, (ii) provides substantially similar services, and (iii) maintains a reasonable quality of care.¹⁹⁸ Although this definition was intended to provide guidance on the transfer of patients when necessary, in practice it raises more questions than it answers. For example, if the debtor’s estate is administratively insolvent, meaning that the debtor does not even have the money to exit bankruptcy, how is the court to determine what “reasonable and best efforts” are?¹⁹⁹ Similarly, the “reasonable quality of care” standard does not provide a specific benchmark by which to measure the care offered at the transferee facility.²⁰⁰ Along with the provisions on the treatment of patient records, these provisions may impose substantial costs on healthcare businesses that are already struggling to stay afloat.²⁰¹

¹⁹² 11 U.S.C. § 101(27A) (2018).

¹⁹³ A “patient,” for Bankruptcy Code purposes, is any individual who obtains or receives services from a healthcare business. *Id.* § 101(40A).

¹⁹⁴ “Patient records” consist of written documents relating to patients or records recorded in magnetic, optical, or other form of electronic medium. *Id.* § 101(40B).

¹⁹⁵ Douglas, *supra* note 7.

¹⁹⁶ 11 U.S.C. § 351.

¹⁹⁷ *Id.* §§ 704(a)(12), 1106(a)(1).

¹⁹⁸ *Id.* § 704(a)(12); see Douglas, *supra* note 7 (explaining further the obligations under the applicable Code section).

¹⁹⁹ Memorandum, *supra* note 84, at 2.

²⁰⁰ See 11 U.S.C. § 704(a)(12).

²⁰¹ Jeffrey D. Sternklar, *The Collision of the New Bankruptcy Code and Health Care Law*, BOS. BAR J., Sept.–Oct. 2006, at 14.

More broadly, the chances of a healthcare debtor becoming administratively insolvent—and therefore unable to emerge from bankruptcy—have risen with BAPCPA’s passage. BAPCPA now requires administrative expense priority for the actual and necessary costs and expenses that the debtor, bankruptcy trustee, and/or regulators incur when closing a healthcare business.²⁰² Because these costs, along with the costs of preserving or destroying patient records and transferring patients, are now deemed non-dischargeable and must be paid in order for the debtor to exit bankruptcy, healthcare debtors may now have a harder time exiting bankruptcy and paying their creditors anything at all. Furthermore, because these potentially significant administrative expense claims trump the claims of other creditors, lenders may provide less favorable terms to healthcare debtors or may discourage these debtors from using the bankruptcy system in the event of a default.²⁰³

BAPCPA further sought to protect the rights and interests of patients by providing for the appointment of a disinterested patient care ombudsman (PCO).²⁰⁴ In general, the court must appoint a PCO within thirty days of the commencement of any healthcare provider bankruptcy case.²⁰⁵ The PCO is responsible for monitoring patient care quality and representing the interests of the healthcare business’s patients more generally.²⁰⁶ The PCO is paid as a “professional person” by the debtor-in-possession or trustee in bankruptcy.²⁰⁷

BAPCPA provides no standards or guidance for how the PCO is to measure the quality of patient care. Instead, the amendments require the PCO to monitor the quality of patient care “to the extent necessary under the circumstances.”²⁰⁸ The PCO must make a report to the court every sixty days, either at a hearing or in writing, about patient care quality.²⁰⁹ Because PCOs are compensated with funds from the bankruptcy estate, they add another cost to the bankruptcy cases of healthcare debtors.²¹⁰

The Code imbues the PCO with no formal powers and no direct ability to influence a plan of liquidation or reorganization. Thus, a PCO’s effectiveness depends greatly on the individual appointed and his or her ability to cooperate with the other parties in the case. The Code does not define the scope of the

²⁰² 11 U.S.C. § 503(b)(8); Memorandum, *supra* note 84, at 2.

²⁰³ Kaplan, *supra* note 191, at 32.

²⁰⁴ 11 U.S.C. § 333.

²⁰⁵ *Id.*

²⁰⁶ Memorandum, *supra* note 84, at 2.

²⁰⁷ 11 U.S.C. § 330(a)(1).

²⁰⁸ *Id.* § 333(b)(1); see Memorandum, *supra* note 84, at 2.

²⁰⁹ 11 U.S.C. § 333(b)(2).

²¹⁰ Memorandum, *supra* note 84, at 2; see 11 U.S.C. § 330(a)(1).

PCO's work,²¹¹ nor does it provide any guidance as to the scope or content of the PCO's court reports.²¹² Moreover, the Code does not give the PCO any particular power to obtain patient information,²¹³ and it does not contemplate any formal role for the PCO in the ultimate restructuring or sale, despite the fact that the PCO may have a valuable perspective about continuing patient care.²¹⁴ Although many PCOs have learned to work around these issues in practice, a significant number of details relating to the PCO's responsibilities are unresolved, leaving PCOs and the parties they work with uncertain as to whether and how the PCO should play a role in the case.²¹⁵ Carving out a defined role for the PCO can be particularly difficult because PCOs are concerned with patients "whose interests do not necessarily coincide with the economic interests of [regulators, creditors, the debtor, and] other case participants."²¹⁶ Thus, unlike in a typical bankruptcy, where the focus is primarily on the business's financial aspects, in a healthcare provider's bankruptcy case, the PCO requirement mandates at least a partial focus on delivery of healthcare to patients.²¹⁷

Finally, BAPCPA created a new exception to the automatic stay, which allows the Secretary of Health and Human Services (HHS) to exclude a debtor from participation in Medicare or any other federal healthcare program.²¹⁸ Practically speaking, this amendment allows HHS to threaten providers with the loss of all future Medicare payments and makes it more difficult for providers to avoid Medicare-related obligations and penalties by declaring bankruptcy.²¹⁹ Indeed, HHS may use its powers to compel the debtor to turn over Medicare overpayments much earlier in a case.²²⁰ The debtor may thus find itself in a financial crunch early on in a bankruptcy case.²²¹

²¹¹ Nancy A. Peterman & Suzanne Koenig, *Patient Care Ombudsman: Why So Much Opposition?*, AM. BANKR. INST. J., Mar. 2006, at 22.

²¹² Andrew Troop & Joseph V. Zujkowski, *Issues Facing Patient Care Ombudsmen*, AMER. BANKR. INST. J., Mar. 2011, at 18.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ Anna Kaluzny, Note, *The Patient Care Ombudsman: Who Should It Be?*, 17 ELDER L.J. 343, 343 (2009).

²¹⁶ *In re Renaissance Hosp.—Grand Prairie, Inc.*, No. 08-43775-11, 2008 WL 5746904, at *2 (Bankr. N.D. Tex. Dec. 31, 2008) (noting that "[t]he result is that the court and other parties cannot view a patient care ombudsman as they do a fiduciary whose job includes improving an estate's value").

²¹⁷ See Sternklar, *supra* note 201, at 14–15 (noting further that "[i]t is not clear precisely how a court is supposed to determine if the quality of health care has, in fact, deteriorated where the parties disagree or what remedy a court is supposed to impose if it finds deterioration in the quality of health care").

²¹⁸ 11 U.S.C. § 362(b)(28).

²¹⁹ Kaplan, *supra* note 191, at 69.

²²⁰ *Id.*

²²¹ *Id.* at 32.

Although it seems clear that one of the driving factors behind BAPCPA's healthcare provisions was to elevate and highlight patient interests in a bankruptcy case, the focus and expertise of many bankruptcy courts continues to be on the economic impact of these provisions on the bankruptcy estate.²²² Thus, the clash among the policy goal of protecting patients' lives and interests, the regulatory goal of providing adequate healthcare to entire communities, and the bankruptcy goal of maximizing estate value, thrives in the post-BAPCPA era. One observer concluded that "the bankruptcy option has become more complicated and more costly" as a result of BAPCPA.²²³ Through its various provisions scattered across the Code, BAPCPA has increased costs for debtors and introduced a new player, the PCO, who must figure out how to reconcile its constituents' interests with the already competing interests of the debtor, its creditors, and its regulators.²²⁴ Far from providing new mechanisms to manage competing interests in a healthcare bankruptcy, BAPCPA merely amplified certain patient-related interests without providing guidance as to how these interests are to be balanced with other important interests in the case.²²⁵

B. Bankruptcy Alternatives

Although BAPCPA made efforts to recognize and address healthcare debtors' distinct difficulties, these debtors have continued to struggle when using the bankruptcy system. Scholars have therefore questioned whether bankruptcy is an effective remedy for healthcare debtors. Some have argued that the needs of healthcare and bankruptcy law can be balanced by the courts, and that with careful pre-bankruptcy planning on the part of healthcare provid-

²²² See Jeff Bohm & Jennifer Chang, *Proper Protection of Patients in Health Care Businesses in Bankruptcy: Continuing Development and Application of Section 333 of the Bankruptcy Code*, 44 UCC L.J. 331, 353 (2012) ("Congress focused on saving the lives of people; the courts have focused on saving the lives of the businesses."); *Workouts Forum*, *supra* note 39, at 20 (observing that in a health care bankruptcy, concerns about patient care are "layered over what typically has just been a debtor/creditor relationship").

²²³ Sternklar, *supra* note 201, at 15.

²²⁴ These increased costs for debtors have sometimes led courts to decline to appoint a PCO in the cases of smaller healthcare businesses. See, e.g., *In re William L. Saber, M.D., P.C.*, 369 B.R. 631, 638 (Bankr. D. Colo. 2007) (determining that the debtor, a single-physician plastic surgery practice, qualified as a "health care business" under the Code but that appointment of a PCO was unnecessary because, inter alia, the associated costs could preclude the debtor from effective relief under the Code).

²²⁵ See, e.g., Bruce A. Markell, *The Sub Rosa Subchapter: Individual Debtors in Chapter 11 After BAPCPA*, 2007 U. ILL. L. REV. 67, 70 (providing another example of how BAPCPA created complications in a different area of bankruptcy law, positing that "Congress underplayed the scope and import" of changes for individual chapter 11 cases by scattering these changes throughout the existing chapter 11, and arguing that a "better way to achieve the changes sought . . . would have been to create a separate subchapter, modeling it on the way chapter 11 now treats railroad reorganizations or the way chapter 7 treats stockbrokers").

ers, bankruptcy can be used to achieve their desired outcomes.²²⁶ Yet, it is often difficult to determine an optimal balance between healthcare and bankruptcy law, and many businesses, healthcare providers included, fail to plan for bankruptcy in any meaningful sense. This has led a growing group to advocate for the use of bankruptcy alternatives, particularly state receiverships, in lieu of bankruptcy as a way for healthcare providers to address financial distress.

A receivership is a creditor's remedy available under state law.²²⁷ When a lender seeks to put an entity into a receivership, a state court appoints a receiver over the business.²²⁸ The receiver's primary task is to liquidate the company, with the subsequent sale approved by the state court.²²⁹ After the sale, the receiver distributes the funds generated in accordance with state law priorities before closing the case.²³⁰

Champions of state receiverships argue that they are a better option than bankruptcy for a number of reasons.²³¹ Receiverships are often faster and more cost-effective than bankruptcy because there is no need to service pre-receivership debts and all of the debtor's assets are preserved for creditors' benefit.²³² A receivership can also protect patients because it allows for an orderly transition to a new operation or a sale without displacing residents or jeopardizing operating licenses.²³³ In the healthcare context in particular, a receivership can be a way for a healthcare facility to remain open while its assets are sold off.²³⁴

Despite these attributes, receiverships are not a substitute for bankruptcy relief.²³⁵ Because receiverships are run under state law, states are typically re-

²²⁶ See, e.g., Palmer & Meises, *supra* note 16, at 21 (positing that the *United Healthcare* district court's balancing approach can be a model for other courts in healthcare provider bankruptcies); Sherman & Mankovetskiy, *supra* note 142, at 14 (describing ways insolvent healthcare debtors and their creditors can manage risk).

²²⁷ Joseph A. Sowell & John C. Tishler, *Receiverships: A Practical (and Perhaps Less Expensive) Alternative to Bankruptcy*, HEALTHLEADERS (Feb. 9, 2009), <https://www.healthleadersmedia.com/finance/receiverships-practical-and-perhaps-less-expensive-alternative-bankruptcy> [<https://perma.cc/XKC9-8XNE>].

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ See, e.g., Peterman et al., *supra* note 20.

²³² *Id.*

²³³ *Id.*; see Chopra, *supra* note 20, at 96 (describing a Connecticut nursing home receivership where "five nursing homes were successfully kept open, turned around, and sold to a qualified purchaser").

²³⁴ Sowell & Tishler, *supra* note 227.

²³⁵ See Chopra, *supra* note 20, at 103–04 (describing the regulations that would have to be enacted, at both the federal and state level, to make receiverships a viable alternative to bankruptcy for a particular group of healthcare businesses).

sponsible for financing the entity while it is in receivership.²³⁶ Many states would not be able to finance the receiverships of all or even a few of the healthcare providers within their borders.²³⁷ In addition, state receivership laws vary widely.²³⁸ Thus, receiverships may be difficult to develop on a larger scale as would be necessary in the event of a widespread financial crisis.

Receiverships are limited in other ways, too. Because receiverships are initiated by creditors, rather than debtors, they do not provide the same protections for debtors that bankruptcy does.²³⁹ If a debtor has a significant number of creditors all vying for the same assets, a receivership may not sort out these creditors in the same value-maximizing way that bankruptcy would because receiverships, unlike bankruptcy, do not require all creditors to participate in the same proceeding.²⁴⁰ Bankruptcy also provides much-needed breathing space to allow the debtor time to assess whether it is better off proceeding as a going concern or liquidating. In the healthcare context, intervention by regulators or creditors through a receivership may heighten the risk of premature, inefficient liquidation.²⁴¹

Unlike in a bankruptcy case, receiverships do not discharge debts, and receivers, unlike bankruptcy trustees or debtors-in-possession, cannot recover

²³⁶ See Richard T. Arrowsmith & Nancy A. Peterman, *Federal and State Oversight of SNFs*, AMER. BANKR. INST. J., May 2018, at 61 (“As states take over [skilled nursing facilities] and likely commence receiverships to do so, they will need to address these issues—most importantly, how to finance the costs of either running or shutting down these facilities.”); Chopra, *supra* note 20, at 103 n.13 (discussing the state’s “potential financial burden” in using receiverships).

²³⁷ See John W. Schoen, *States in Crisis: Embroiled in the Worst Budget Battles Since the Great Recession*, CNBC (July 11, 2017), <https://www.cnbc.com/2017/07/11/states-in-crisis-the-worst-budget-battles-since-the-great-recession.html> [<https://perma.cc/ANB8-R4RE>] (describing current and future state budget concerns). While a state-level bailout may be another bankruptcy alternative, these budget concerns would also likely prohibit the state from bailing out a failing healthcare institution. *See id.*

²³⁸ See Chopra, *supra* note 20, at 74 (observing that some states may not have adequate receivership regulations).

²³⁹ See MARY GRACE DIEHLE ET AL., STATE BAR OF GA., INTERSECTION OF RECEIVERSHIPS AND BANKRUPTCY 3 (2010), <https://haysconsulting.net/wp-content/uploads/2010/11/Intersection-of-Receivership-and-Bankruptcy.pdf> [<https://perma.cc/4HUN-Q7A3>]; Sowell & Tishler, *supra* note 227 (exploring advantages and disadvantages of receiverships and bankruptcies); Christine L. Myatt, *Alternatives to Bankruptcy (Receivership)*, NEXSEN PRUET (June 28, 2016), <https://www.nexsenpruet.com/insights/receiverships-101> [<https://perma.cc/A7NG-CWKS>].

²⁴⁰ James A. Chatz & Joy E. Levy, *Alternatives to Bankruptcy*, 17 NORTON J. BANKR. L. & PRAC. 149, 151 (2008); see Lili Liu & Michael Waibel, *Subnational Insolvency: Cross-Country Experiences and Lessons* 6 (World Bank Econ. Pol’y & Debt Dep’t, Working Paper No. 4496, 2008), <https://documents.worldbank.org/curated/en/332531468161672312/pdf/wps4496.pdf> [<https://perma.cc/46UW-9T2J>] (“When widespread defaults occur, uncoordinated enforcement by individual creditors is impracticable, costly and potentially harmful to the interests of a majority of creditors.”).

²⁴¹ See Chatz & Levy, *supra* note 240, at 150; see also Liu & Waibel, *supra* note 240, at 32 (“Without an ex-post insolvency mechanism, ex-ante regulation can easily turn into excessive administrative control and bargaining . . .”).

preferences.²⁴² In addition, the goal of a receivership is to protect the interests of the particular creditor seeking the receivership, and there is little reason to think that a receivership will better manage competing interests compared to a bankruptcy, where more stakeholders are present due to the collective nature of the bankruptcy process.²⁴³ Instead, bankruptcy's court-driven process, which requires dissenting creditors to fall in line, may be more beneficial when creditors are competing for the debtor's assets. Thus, receiverships are an alternative to, but not a complete replacement for, bankruptcy's debtor protections and creditor-management tools.

Of course, receiverships are not the only alternatives to bankruptcy for a struggling healthcare business. But some other out-of-bankruptcy workouts, such as mergers, have recently come under scrutiny for the effect they have on the price of medical care.²⁴⁴ Without a consistent bankruptcy option, “[f]ailing hospitals often have little choice but to be acquired or go out of business.”²⁴⁵ The merger of healthcare businesses has been found to increase costs for patients.²⁴⁶ Thus, while alternatives to bankruptcy may be useful to—or even preferable for—healthcare entities under certain circumstances, they are not a complete replacement for bankruptcy, and they come with their own risks. There will therefore still be occasions when a healthcare provider should seek bankruptcy relief. Finally, receiverships and other alternatives to bankruptcy suffer from the same problems identified in Part II: they are general remedies, not specifically designed for healthcare debtors, and they lack an organizing principle for reconciling competing interests.

The bankruptcy process continues to pose challenges for healthcare providers. BAPCPA's reforms to the Code left many issues unaddressed and created new problems even as the drafters attempted to provide additional recognition to healthcare debtors' unique needs. Alternatives to bankruptcy may be viable in some cases, but they are not substitutes for the bankruptcy process's unique attributes. The difficulties healthcare debtors face in bankruptcy have led some to speculate that “a healthcare business can't file for bankruptcy and

²⁴² Chatz & Levy, *supra* note 240, at 151.

²⁴³ David Wallace, *Setting the Record Straight: Bankruptcy vs. Receivership*, L.A. DAILY J. (Mar. 6, 2013), <http://www.trigild.com/wp-content/uploads/2013/03/Trigild-LADJ-3-6-13.pdf> [<https://perma.cc/CK6T-AK5H>].

²⁴⁴ See Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), <https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html?module=inline> [<https://perma.cc/88LX-8JVZ>] (explaining how hospital mergers often lead to increased costs for patients as healthcare systems consolidate market share).

²⁴⁵ *Id.*

²⁴⁶ *Id.*

succeed, . . . they always fail.”²⁴⁷ Indeed, in this highly regulated and socially sensitive environment, the ordinary bankruptcy process seems substantially insufficient.

IV. REORGANIZING HEALTHCARE BANKRUPTCY

The previous Parts have shown that bankruptcy law’s treatment of healthcare debtors is incomplete and inconsistent because the Code does not adequately address these debtors’ unique circumstances. While bankruptcy courts regularly interpret and apply bankruptcy law to healthcare debtors, many of these interpretations have been inconsistent or have weakened bankruptcy as a tool for healthcare providers. The precarious financial state of many healthcare providers, along with the importance of these providers to individuals’ well-being, makes it critical to ask: what role, if any, should bankruptcy law play for distressed healthcare businesses in the future? To answer this question, this Part first examines other instances where a bankruptcy “fit” has been called into question and then considers two possible avenues for improving the bankruptcy process for healthcare debtors.²⁴⁸

A. *When Is Bankruptcy Appropriate?*

Healthcare is not the only industry where observers have questioned the suitability of a bankruptcy resolution. This Subsection describes two other industries—banks and railroads—where scholars have debated the appropriateness of a bankruptcy mechanism and draws parallels to the healthcare industry.²⁴⁹

Debates about whether bankruptcy is a good option for a particular industry or business arise in part because scholars often disagree about bankruptcy’s core purposes.²⁵⁰ Despite this debate, there are a few broad areas of general agreement. For example, scholars mostly agree that a bankruptcy reorganization mechanism is appropriate when it enhances value for the parties.²⁵¹ Many

²⁴⁷ *Workouts Forum*, *supra* note 39, at 38; see *ABI Podcast*, *supra* note 39 (noting that “no one” has been able to “fix” or turn around healthcare financial distress).

²⁴⁸ See *infra* notes 250–323 and accompanying text.

²⁴⁹ See *infra* notes 250–294 and accompanying text.

²⁵⁰ See Barry E. Adler, *Financial and Political Theories of American Corporate Bankruptcy*, 45 STAN. L. REV. 311, 311 (1993) (arguing against the “common pool” justification for corporate bankruptcy); Douglas G. Baird & Thomas H. Jackson, *Corporate Reorganizations and the Treatment of Diverse Ownership Interests: A Comment on Adequate Protection of Secured Creditors in Bankruptcy*, 51 U. CHI. L. REV. 97, 98 (1984) (noting that bankruptcy serves “a unique, but limited, function in our society”); Elizabeth Warren, *Bankruptcy Policymaking in an Imperfect World*, 92 MICH. L. REV. 336, 338 (1993) (discussing “the various and competing goals that underlie the bankruptcy system”). See generally David A. Skeel, Jr., *When Should Bankruptcy Be an Option (for People, Places, or Things)?*, 55 WM. & MARY L. REV. 2217 (2014).

²⁵¹ Bruckner, *supra* note 39, at 241.

scholars also believe that bankruptcy relief should be widely available.²⁵² With respect to healthcare in particular, some argue that bankruptcy has value when it prevents the closure of healthcare facilities that are sustaining or prolonging patient lives.²⁵³

In the wake of the 2008 financial crisis, the issue of whether to allow banks—and particularly any systemically important financial institution (SIFI)—to use bankruptcy has been an increasingly important topic of scholarly debate.²⁵⁴ Like healthcare businesses, banks are subject to significant regulations. Notably, bank regulators make key decisions about how assets get distributed before an insolvency process even begins.²⁵⁵ Scholars such as Stephen Lubben have pointed out that bankruptcy’s distributional policy has little effect in the SIFI context.²⁵⁶ If, as many have contended, bankruptcy’s primary focus is about resolving competing creditors’ claims to limited assets,²⁵⁷ bank insolvency is focused instead on advancing legislative policy goals defined prior to insolvency.²⁵⁸ Put differently, because regulators make all of the significant decisions in a bank insolvency in advance of any court procedure getting started, there is at best a small role left for the bankruptcy judge to play in a SIFI insolvency and little point in going through the bankruptcy process.²⁵⁹

This conclusion about banks and bankruptcy might at first glance also make sense in the healthcare context. As described in Part II, state and federal healthcare regulators often assert substantial authority over the debtor’s finances and operational capabilities.²⁶⁰ The decisions these regulators make when a healthcare institution experiences financial distress have an undeniable influence on the value of the debtor’s estate, creditor rank, and distribution of assets. In addition, a critical group of affected parties—depositors in the case

²⁵² See *id.* at 242 (describing this belief as a “default assumption”).

²⁵³ *Id.* at 248.

²⁵⁴ See Jonathan C. Lipson, *Against Regulatory Displacement: An Institutional Analysis of Financial Crises*, 17 U. PA. J. BUS. L. 673, 730 (2015) (concluding that an entirely new Bankruptcy Code chapter for banks “only makes for greater complexity and uncertainty”). See generally Jackson, *supra* note 21 (proposing a chapter 14 of the Bankruptcy Code that would provide bankruptcy for banks); Levitin, *supra* note 21 (arguing against bankruptcy for financial institutions); Stephen J. Lubben, *A Functional Analysis of SIFI Insolvency*, 96 TEX. L. REV. 1377 (2018); Skeel, *supra* note 21; Roe, *supra* note 21 (arguing that bank bankruptcy would be a “mistake of potentially crisis-sized proportions”).

²⁵⁵ Lubben, *supra* note 254, at 1392.

²⁵⁶ *Id.*

²⁵⁷ See Kenneth Ayotte & David A. Skeel, Jr., *Bankruptcy Law as Liquidity Provider*, 80 U. CHI. L. REV. 1557, 1561 (2013) (summarizing the creditors’ bargain theory of bankruptcy).

²⁵⁸ Lubben, *supra* note 254, at 1393.

²⁵⁹ *Id.* at 1396.

²⁶⁰ See *supra* notes 79–190 and accompanying text.

of banks and patients in the case of healthcare—may have difficulty coordinating and negotiating their interests in a bankruptcy case.²⁶¹

Healthcare debtors differ from banks, however, because most healthcare businesses have not been excluded from bankruptcy. Part II also demonstrated that bankruptcy courts can sometimes assert their authority and make decisions independently from healthcare regulators.²⁶² For example, the court in *In re Bayou Shores* expressed that the healthcare facility in question could continue operating post-bankruptcy by signaling to regulators that the court was removing the core obstacle facing the facility's continued operation—failure to assume a Medicare provider agreement.²⁶³ Bankruptcy courts' expertise in assessing a business's financial situation may permit a viable healthcare business to continue operating when a regulator may prefer to shut it down. Furthermore, unlike banks, healthcare businesses lack a robust set of non-bankruptcy rules and procedures that can accommodate them in the event they experience financial distress or insolvency. Finally, healthcare regulators, despite their tremendous influence over a bankruptcy case, do not have bank regulators' ability to simply seize and sell an insolvent entity's assets.²⁶⁴

The recent scholarly debate about banks and the questions this Article raises about healthcare echo past debates regarding how to design appropriate bankruptcy relief for railroads. In the past, a receivership was a common method of resolving a railroad's financial distress. Yet, these receiverships were largely ineffective at addressing a railroad's financial problems.²⁶⁵ This is because a receivership would only work if the debtor and its creditors could agree on a plan, and distressed railroads were very much dependent on their creditors to make the process work.²⁶⁶ But railroads had no way of compelling creditor participation in a plan, and because the railroad's creditors were in a comparatively stronger position, a railroad always ran the risk of failure if it attempted resolution of its debts through a receivership.²⁶⁷ Consequently, the debtor's management had the incentive to propose a plan that provided for “the smallest possible abrogation” of creditor claims, with the typical result being

²⁶¹ See Lipson, *supra* note 171, at 677.

²⁶² See *supra* notes 79–190 and accompanying text.

²⁶³ 525 B.R. 160, 168–69 (Bankr. M.D. Fla. 2014), *rev'd on other grounds*, 533 B.R. 337 (M.D. Fla. 2015).

²⁶⁴ See Lipson, *supra* note 254, at 709 (noting that there is no equivalent to the Federal Deposit Insurance Corporation—a regulator that can become a receiver or take over a bank—in the healthcare context).

²⁶⁵ Stephen J. Lubben, *Railroad Receiverships and Modern Bankruptcy Theory*, 89 CORNELL L. REV. 1420, 1468 (2004).

²⁶⁶ *Id.*

²⁶⁷ *Id.*

that the railroad's financial structure was not substantially altered.²⁶⁸ The result of many receiverships was therefore "under-reorganization" of the railroad, meaning that financial difficulties were likely to arise again in the future.²⁶⁹ For this reason, bankruptcy emerged as a competing solution to address railroads' financial distress.

Like banks and the healthcare industry, railroads are heavily regulated. Among other federal agencies with jurisdiction over the railroads,²⁷⁰ the Federal Railroad Administration (FRA) promulgates and enforces rail safety regulations,²⁷¹ and the Surface Transportation Board (STB) has broad economic oversight of the railroads.²⁷² State agencies also play a role in the regulation of railroads that cross their borders.²⁷³ The presence of these regulators indicates that, like in the healthcare context, operation of a railroad requires attention to public safety in addition to purely pecuniary interests. Thus, when a railroad experiences financial distress, it is critical to take both the interests of regulators and the public into account.

Congress sought to make bankruptcy responsive to these regulatory and public interests in part by creating a subchapter (Subchapter IV) of chapter 11 that distinctly addresses railroad reorganizations.²⁷⁴ Through legislative action, Congress recognized that railroad bankruptcies, by virtue of these competing interests, raised different concerns than other business reorganizations and merited distinct treatment within the bankruptcy system.

Many of Subchapter IV's provisions seek to harmonize pecuniary and public safety interests. Notably, § 1163 of the Code provides for the STB to appoint a trustee to operate the railway in bankruptcy, with the aim of creating minimal disruption in rail services.²⁷⁵ Section 1164 provides that railroad regu-

²⁶⁸ *Id.* at 1468–69.

²⁶⁹ *Id.* at 1472–73.

²⁷⁰ *See, e.g., About the National Transportation Safety Board*, NAT'L TRANSP. SAFETY BOARD, <https://www.nts.gov/about/Pages/default.aspx> [<https://perma.cc/4KKJ-VZ8Z>] (describing the role of the National Transportation Safety Board, which investigates railroad accidents).

²⁷¹ *About FRA*, FED. RAILROAD ADMIN., <https://www.fra.dot.gov/Page/P0002> [<https://perma.cc/THV6-8BEX>].

²⁷² *About STB*, SURFACE TRANSP. BOARD, <https://www.stb.gov/stb/about/overview.html> [<https://perma.cc/Z6R5-9HMY>].

²⁷³ *See, e.g., Rail Safety*, CA. PUB. UTIL. COMM'N, <http://www.cpuc.ca.gov/rail/> [<https://perma.cc/2WBU-XYR7>] (noting that the California Public Utilities Commission has safety and security regulatory authority over all rail transit agencies in California); *State Laws & Regulations Affecting Highway-Rail Grade Crossings*, FED. RAILROAD ADMIN., <https://www.fra.dot.gov/StateLaws> [<https://perma.cc/YVK7-L75J>] (discussing state agency authority for highway-rail grade crossings).

²⁷⁴ 11 U.S.C. §§ 1161–1174 (2018).

²⁷⁵ *Id.* § 1163; *see* Judy Harrison & Nick Sambides Jr., *Maine-Based Railway Involved in Quebec Crash that Killed 47 Files for Bankruptcy*, BANGOR DAILY NEWS (Aug. 8, 2013), <https://bangordailynews.com/2013/08/07/business/railway-involved-in-quebec-crash-that-killed-47-files-for-bankruptcy/>

lators may appear and be heard on any issue in a case; however, these entities may not appeal from any judgment, order, or decree in the case, because the Code treats them as “intervening parties,” not “parties in interest.”²⁷⁶ In addition, § 1165 explicitly requires the court and the trustee in a railroad reorganization to “consider the public interest in addition to the interests of the debtor, creditors, and equity security holders.”²⁷⁷ The legislative history indicates that this provision exists because the public interest “is an important factor in railroad reorganization, which distinguishes [it] from other business reorganizations.”²⁷⁸ Finally, § 1166 provides an organizing principle of sorts for railroad reorganizations, explaining that, with certain exceptions, the trustee and the debtor are subject to the Interstate Commerce Act, and the trustee is subject to orders from regulators to the same extent as the debtor would be if not in bankruptcy.²⁷⁹ Conversely, it also provides that any regulatory order that would require the expenditure “or the incurring of an obligation for the expenditure” of money from the estate will not be effective unless approved by the court.²⁸⁰ Thus, § 1166 contemplates a principle where monetary-related regulatory orders are subject to court approval. Other provisions of Subchapter IV explain how actions taken in a railroad reorganization interact with other laws, policies, and regulations pertaining specifically to railroads.²⁸¹

Like the financial distress of a SIFI or a railroad, the distress of a healthcare institution can have significant negative externalities and can trigger the involvement of multiple regulatory agencies. Much attention to date has been focused on finding an appropriate resolution mechanism for banks; however, the healthcare industry’s precarious financial state, the problems created by the ACA and its aftermath, and the industry’s sizeable impact on the U.S. economy as a whole indicate that it is at least as important to ensure that healthcare businesses have the tools they need to navigate financial distress going forward. Congress’s treatment of railroad reorganizations in bankruptcy

[<https://perma.cc/KK7X-47A6>] (describing this process in the context of a recent railroad reorganization).

²⁷⁶ 11 U.S.C. § 1164.

²⁷⁷ *Id.* § 1165.

²⁷⁸ S. REP. NO. 95-989, at 133 (1978), as reprinted in 1978 U.S.C.C.A.N. 5787, 5919.

²⁷⁹ 11 U.S.C. § 1166.

²⁸⁰ *Id.*

²⁸¹ *See, e.g., id.* § 1167 (providing that “neither the court nor the trustee may change the wages or working conditions of employees of the debtor established by a collective bargaining agreement that is subject to the Railway Labor Act”); *id.* § 1170 (requiring the trustee to apply for abandonment with the STB if abandonment would normally require the Board’s approval outside of bankruptcy); *id.* § 1172(b) (articulating specific provisions for seeking the STB’s approval in the event of a new entity taking over the debtor’s operations); *id.* § 1173 (making plan confirmations contingent on consistency with the public interest).

can provide a roadmap for how to address similar issues arising in the healthcare context.

Regardless of how a healthcare business uses bankruptcy—to reorganize,²⁸² to liquidate,²⁸³ or to engage in a structured asset sale²⁸⁴—the biggest differences between a healthcare provider bankruptcy and that of another type of business are the presence and involvement of patients and regulatory agencies. These additional parties, who are significant players in the healthcare industry, complicate the case.²⁸⁵

When healthcare providers seek bankruptcy relief, the conflicts between healthcare regulation and bankruptcy cannot be ignored. As previously discussed, healthcare regulators' priorities and goals may impede bankruptcy's ability to maximize returns to creditors.²⁸⁶ At the same time, the bankruptcy process, by requiring coordination of all parties, can provide a check on overzealous or financially-motivated regulatory concerns. Regulators, who commonly have their sights set on damage control, may be unable or unwilling to assess whether a liquidation is truly in the best interests of the provider, its patients, and its creditors compared to alternatives such as a restructuring.²⁸⁷ Bankruptcy can provide breathing space, critical time for the parties (and a court) to assess the needs of the debtor, its patients, its creditors, and the community at large.²⁸⁸ Bankruptcy also provides a single forum in which the debtor can comprehensively address its creditors' claims, in addition to federal preemption over conflicting state laws.²⁸⁹

Recent research indicates that healthcare “debtors’ stated reasons for filing comport with why most businesses file chapter 11,” including “decreased

²⁸² See Guice, *supra* note 139, at 128 (detailing the clashing goals in healthcare provider bankruptcies).

²⁸³ See Stern & Fragomeni, *supra* note 15, at 182 (discussing the need to involve state healthcare regulators during a liquidation).

²⁸⁴ See Urban & Berkowitz, *supra* note 86, at 89 (“Health care bankruptcies often involve the sale of the debtor’s assets.”).

²⁸⁵ See Samole, *supra* note 13 (describing the “playing field” of a healthcare provider bankruptcy case, namely, the different parties that may be involved in the case).

²⁸⁶ See *supra* notes 145–172 and accompanying text.

²⁸⁷ See Lipson, *supra* note 254, at 680 (noting that “regulators may actually exacerbate concentration and complexity” in some cases).

²⁸⁸ See Laura N. Coordes, *Gatekeepers Gone Wrong: Reforming the Chapter 9 Eligibility Rules*, 94 WASH. U. L. REV. 1191, 1212 (2017) (noting that bankruptcy is uniquely designed to provide breathing space via the automatic stay). *But see* Christopher M. Towery & Jason H. Watson, *Recent Developments in Chapter 11*, 2018 NORTON ANN. SURV. BANKR. L. 941, 959 (“Often, because of the § 362(b)(4) exception, filing a bankruptcy case does not effectuate the breathing room a [healthcare] debtor may anticipate.”).

²⁸⁹ See Lipson, *supra* note 254, at 680 (noting that courts “tend to reduce information asymmetries, effectively align incentives, and redistribute losses in ways that are . . . more likely to be interpreted as legitimate”).

revenue, financial structure, and poor management.”²⁹⁰ Thus, healthcare debtors often need bankruptcy for the same reasons many other businesses seek bankruptcy. Healthcare debtors also need bankruptcy because the Contracts Clause prohibits state actors from modifying contracts on a non-consensual basis.²⁹¹ This hurdle can only be overcome through federal bankruptcy law. In part because provider agreements are typically characterized as such, executory contracts are a significant part of healthcare provider bankruptcies, making bankruptcy a necessary step for some healthcare providers seeking to sell or reject these agreements without being burdened with the full cost of any damages.²⁹² In addition, an orderly reorganization process may be beneficial to protect the patients that are at risk whenever a healthcare institution experiences severe financial distress.²⁹³

Although bankruptcy presents particular challenges and conflicts in the healthcare setting, it may also be a necessary and valuable option for healthcare debtors faced with multiple creditors and the need for time to assess the path forward.²⁹⁴ It is true that the healthcare industry is subject to near constant change; however, healthcare debtors have consistently shown a need for basic bankruptcy functions over the years. Although the current bankruptcy system fails to serve healthcare business debtors in many ways, if the bankruptcy process can work in harmony with the broader regulatory and social healthcare environment, many of the problems healthcare debtors face in bankruptcy would be significantly reduced. The next Subsection offers two proposals to accomplish this goal.

B. Proposals

Healthcare is certainly not the only area where the Code has conflicted with other regulations or statutory schemes.²⁹⁵ Yet, due to the high stakes in a healthcare bankruptcy—the health of the nation’s population—there is a genuine need to strike a careful balance among the interests of all parties affected

²⁹⁰ Foohey, *supra* note 13.

²⁹¹ U.S. CONST. art. I, § 10, cl. 1.

²⁹² For example, although rejection of an executory contract in bankruptcy gives rise to damages, those damages are considered to have arisen prepetition; thus, the contract counterparty is considered to be an unsecured creditor and receives payment for those damages on a pro rata basis with other unsecured creditors. *See generally* NLRB v. Bildisco & Bildisco, 465 U.S. 513 (1984).

²⁹³ Bruckner, *supra* note 39, at 262.

²⁹⁴ *See generally* Chopra, *supra* note 20 (describing these challenges in the context of financially distressed continuing care retirement communities).

²⁹⁵ *See generally* Bd. of Governors of the Fed. Reserve Sys. v. MCorp Fin., Inc., 502 U.S. 32 (1991) (discussing conflicts between bankruptcy and banking laws); Midlantic Nat’l Bank v. N.J. Dep’t of Env’tl. Prot., 474 U.S. 494 (1986) (discussing conflicts between bankruptcy and environmental laws); *Bildisco & Bildisco*, 465 U.S. 513 (discussing conflicts between bankruptcy and labor law).

by a healthcare institution's financial distress.²⁹⁶ Healthcare's unique regulatory and social environments create tensions that must be resolved with the policies and purposes underlying the Code whenever a healthcare provider files for bankruptcy. With this in mind, the following Subsections map out two possibilities for reforming bankruptcy law to help the affected parties in a healthcare provider bankruptcy case assess the broader impacts of their decisions: (1) further, discrete changes to the Code; and (2) creation of new Code subchapters specifically addressing the needs of distressed healthcare businesses, modeled in part off of Congress's treatment of railroad reorganizations.²⁹⁷

1. BAPCPA Round Two: More Specialization

One fairly straightforward way to address fundamental conflicts between the Code and healthcare regulation is simply to make more amendments to the Code, similar to what Congress did with BAPCPA. There would be no structural change to the Code; instead, individual Code sections would be adjusted and new provisions added to further address healthcare debtors' particular needs. Such changes, while significant, are likely to be less disruptive to current bankruptcy practice than this Article's alternative proposal. As a tactic requiring relatively targeted changes, such an approach may also be more politically feasible than one that alters the Code's overall structure.²⁹⁸

The American Bankruptcy Institute's Commission to Study the Reform of Chapter 11 (the Commission) proposed exactly this type of change with respect to the treatment of small- and medium-sized enterprises (SMEs) under the Code. After years of study, the Commission concluded that the Code no longer works as intended for SMEs, primarily because current practice under the Code is too slow and costly for most SMEs to do much beyond sell their going concern assets or liquidate.²⁹⁹

The Commission acknowledged that Congress had tried to address these concerns through BAPCPA but, much like BAPCPA's effects in the healthcare context, the reforms made the process more "challenging and counterproductive" for SME debtors.³⁰⁰ Like healthcare debtors, SMEs were turning to alter-

²⁹⁶ See *Workouts Forum*, *supra* note 39, at 20 (describing the "real human cost" that separates healthcare from other industries).

²⁹⁷ See *infra* notes 298–323 and accompanying text.

²⁹⁸ See Lipson, *supra* note 254, at 729 ("[A]ny effort to amend the Bankruptcy Code is, itself, likely to be politically volatile."); *ABI Podcast*, *supra* note 39 (noting that "there is a lot of politics involved" in the healthcare industry).

²⁹⁹ AMER. BANKR. INST., COMMISSION TO STUDY THE REFORM OF CHAPTER 11 at 277 n.985 (2014).

³⁰⁰ *Id.* at 281.

natives to bankruptcy, such as receiverships, to address their fiscal distress.³⁰¹ But the Commission observed that receiverships and other remedies presented their own sets of problems, such as inconsistency and lack of transparency.³⁰²

To address its concerns, the Commission proposed numerous concrete reforms to the Code.³⁰³ These reforms required modification to existing Code provisions and included changes such as no oversight by an unsecured creditors committee, the appointment of an estate neutral to oversee the case, and specific amendments to address problems with plan timing, content, and confirmation.³⁰⁴ In all, the Commission sought to strike an appropriate balance between the need to assess an SME debtor's viability early in a case while still allowing viable SME cases the opportunity to succeed.³⁰⁵ In large part, the Commission's proposed changes were designed to simplify the bankruptcy process for SME debtors by "reducing costs and barriers" and "providing tools to facilitate effective reorganizations for viable companies."³⁰⁶ The Commission correctly recognized that chapter 11's current, "one-size-fits-all" approach was not working for all debtors.³⁰⁷ Thus, the Commission sought to address cost and complexity concerns for SMEs while acknowledging that the Bankruptcy Code's overarching framework was appropriate for most SME debtors.

Modifying the Code to create additional specialized provisions addressing the needs of healthcare debtors, similar to the Commission's approach for SMEs, may well be an attractive option. Healthcare debtors face similar challenges to those that were facing SMEs: BAPCPA has made the process more complicated for both debtor types, and both healthcare providers and SMEs have sought out alternatives to bankruptcy. Changes to the Code to address situations uniquely found in healthcare could resolve the issues with respect to eligibility, treatment of provider agreements and excise taxes, valuation, jurisdiction, the reach of the automatic stay, and the question of classifying collection of overpayments described above. Most of these issues simply require clarification in the healthcare context. For example, Congress could delineate the scope of healthcare entities eligible for bankruptcy and definitively decide whether provider agreements constitute executory contracts. Congress could also clarify the extent to which bankruptcy courts have jurisdiction over Medicare- and Medicaid-related disputes that have not run their course in the ad-

³⁰¹ *Id.* at 282.

³⁰² *Id.* at 283.

³⁰³ *Id.* at 284.

³⁰⁴ *Id.* at 289.

³⁰⁵ *Id.* at 285.

³⁰⁶ *Id.* at 290.

³⁰⁷ *Id.* at 284.

ministrative context. These changes would require discrete statutory fixes, such as clarifications or additions to existing statutory language.

The benefits of additional specialization within the existing statutory framework lie primarily in clarity and consistency. Even if Congress decides to enact reforms that make it more difficult for healthcare businesses to use the bankruptcy system (by, for example, saying that providers must exhaust their administrative remedies prior to raising issues in bankruptcy court), healthcare businesses and the entities that interact with them would know what to expect when engaging in a bankruptcy proceeding. Thus, simply clarifying the Code by adding more provisions specific to the healthcare context could go a long way toward making the bankruptcy process more predictable for healthcare business debtors.

Unlike with SMEs, however, healthcare debtors must grapple with the presence of regulators and the impacts of their financial distress on patients. Simply adjusting existing Code provisions, without more, may not go far enough in addressing the balance of power between the bankruptcy judge and regulators responsible for ensuring adequate healthcare to citizens. In addition, as experience with BAPCPA demonstrates, further reforms to discrete sections of the Code risk muddying the waters, in part because Congress may not be considering these reforms' overall impact on the healthcare industry.

Clarifying amendments to the Code, however comprehensive, would also likely not address a key problem Part II identified: the Code's lack of an organizing principle that applies uniquely to healthcare debtors. Bankruptcy's value, in part, can be attributed to its ability to eliminate collective action problems and provide a cohesive priority scheme for all parties involved in a case. But the lack of a scheme that incorporates healthcare regulators and patient interests means that courts have little guidance as to how to balance these competing concerns. For this reason, it may be necessary to consider further adjustments to the structure of the Code.

2. Healthcare Business Bankruptcy Subchapters

Congress could more comprehensively help judges assess the challenges of healthcare provider bankruptcies by amending the Code to create two new subchapters addressing the liquidation and reorganization of healthcare debtors. These subchapters would be housed within two of the existing chapters available to healthcare debtors: chapter 7 (liquidation) and chapter 11 (reorganization).³⁰⁸

³⁰⁸ A similar subchapter for chapter 9 healthcare debtors may not be feasible due to additional state and federal concerns that arise in the chapter 9 bankruptcy process. For this reason, this Article does not contemplate such a subchapter for chapter 9 healthcare debtors, although it may be possible to include a subchapter for these healthcare debtors with further adjustments.

Creating specific healthcare subchapters would allow Congress to address both of the primary problems Part II identified with respect to healthcare provider bankruptcies. Using the subchapters, Congress could make specific clarifications with respect to healthcare debtors without concern that these clarifications would have broader impacts across the Code as a whole. The subchapter design would also allow Congress to articulate a specific organizing principle applicable uniquely in the healthcare context, similar to what it did in the railroad reorganization subchapter. Finally, because the early engagement of regulators is often crucial to a successful healthcare provider bankruptcy, Congress could use the healthcare subchapters to define and clarify regulators' roles and perhaps facilitate early coordination with regulators.

Undoubtedly, creating new subchapters within the Code for healthcare debtors would be viewed as a radical reform, but such reform is justified for three primary reasons. First, as discussed, healthcare provider bankruptcies are simply different from the bankruptcies of other businesses. The requirements of regulatory agencies and patients add a distinct dimension to healthcare bankruptcy cases. In these cases, the judge must balance these demands with the interests of creditors and with bankruptcy's goal of value maximization. Second, the healthcare industry is a significant component of the U.S. economy. Because healthcare financial distress can result in considerable negative repercussions for the economy as a whole, healthcare provider bankruptcies deserve particular attention. Finally, the healthcare regulatory environment is constantly changing, making the need to create an organizing principle in bankruptcy both urgent and compelling. Providing separate subchapters for healthcare provider bankruptcies will allow future adjustments to these subchapters to be made directly in response to industry changes in a way that will not impact the process for other debtors.³⁰⁹ In short, creating these subchapters, while perhaps a more onerous task than more discrete reform efforts, allows the Code to better address the distinct needs of an important and significant industry.

Although the exact content of the healthcare provider bankruptcy subchapters would be subject to debate and approval by Congress, and ideally after significant consultation with professional organizations and industry leaders, the following features should be considered for inclusion. First, a centerpiece of the subchapters should be an organizing principle to help bankruptcy courts balance regulatory and patient concerns with the financial interests of the debtor and its creditors. To craft this organizing principle, Congress should recognize the bankruptcy court's expertise in dealing with financial issues by

³⁰⁹ *ABI Podcast*, *supra* note 39 (describing the various changes, innovations, and disruptions in the healthcare sector and how these changes will produce "winners" and "losers").

giving deference to the court with respect to decisions involving these issues. On the other hand, courts should defer to regulators and their expertise in addressing public health and safety issues when questions of that nature arise. When issues involving a mix of financial and public health interests arise, the court should determine which interests predominate and proceed accordingly.³¹⁰

By allowing deference to regulatory concerns in some, but not all situations, Congress could balance regulators' need to protect the public health with the bankruptcy goals of a healthcare institution and its creditors. The goal is to create meaningful opportunities for regulators to work within the bankruptcy process and to set clearer expectations on the extent and scope of regulator involvement in healthcare provider bankruptcies.

When assessing the power of regulators with respect to the bankruptcy court, Congress should keep in mind established principles that apply elsewhere in the bankruptcy context to delineate when a government interest should override bankruptcy policy. For example, government requests for exceptions to the automatic stay are granted or denied based on whether the government entity in question is acting for a primarily pecuniary or public purpose.³¹¹ If a court finds that the government entity is seeking an exception to the automatic stay to pursue a predominantly pecuniary purpose (for example, the collection of money), the court will not grant the exception. Congress applied this same general principle when it created the railroad reorganization subchapter, providing for court approval when regulators' decisions resulted in the expenditure of estate funds.³¹² Similarly, regulatory actions should be assessed by the bankruptcy court for their underlying purpose. If the purpose is primarily pecuniary in nature, such action or proposed action should receive less deference in the bankruptcy process than if the regulator's interest is motivated primarily by public health and safety concerns.

The subchapters should also include an explicit, participatory mechanism for regulators and the PCO, modeled off of the subchapter for railroads, where regulators are considered "intervening parties" rather than "parties in inter-

³¹⁰ A recent Supreme Court decision provides a helpful parallel in sorting out mixed questions. In *U.S. Bank National Ass'n v. Village at Lakeridge, LLC*, Justice Kagan's majority opinion notes that "the standard of review for a mixed question [of law and fact] depends on whether answering it entails primarily legal or factual work." 138 S. Ct. 960, 967 (2018). Similarly, the amount of deference given to regulators for a mixed financial and public health question should depend on whether resolving the issue involves primarily a financial solution or a policy solution.

³¹¹ See, e.g., *United States v. Vanguard Healthcare, LLC*, 565 B.R. 627, 632 (M.D. Tenn. 2017) (discussing this test in the context of the § 362(b)(4) automatic stay exception); *Bayou Shores*, 525 B.R. at 172 (discussing an example of the denial of an exception because of a predominantly pecuniary purpose).

³¹² 11 U.S.C. § 1166.

est.”³¹³ A similar provision also appears in § 1109 of the Code, which provides that the Securities and Exchange Commission (SEC) may appear in a case and raise and be heard on any issue.³¹⁴ Although the SEC may not appeal from a judgment, order, or decree in a case, it may still participate in any appeal by any other party in interest. Like railroad regulators and the SEC, healthcare regulators and PCOs could also be classified as “intervening parties,” which may better define their role and limitations in a bankruptcy case.

Finally, using the subchapters, Congress could provide clarification on many of the issues that are currently unsettled in healthcare provider bankruptcies, such as debtor eligibility, the treatment of provider agreements and quality assurance fees, bankruptcy court jurisdiction, and the proper characterization of government recovery of overpayments. A benefit of using subchapters to make these clarifications is that Congress can implement them without concern that they will have larger ripple effects across the Code.³¹⁵ Particularly because the healthcare industry is prone to rapid change, addressing these changes through subchapters mitigates the need for Congress to take a look at the Code as a whole whenever changes to the healthcare provider bankruptcy process are desired.

The creation of subchapters for healthcare business bankruptcies would signal Congress’s recognition of something practitioners have been saying for decades: healthcare business bankruptcies are simply different. Specifically, the heavily regulated structure of a healthcare business and the business’s core functions raise different concerns in bankruptcy compared with other business debtors.³¹⁶ Through the creation of subchapters, Congress can recognize both the significance and the distinctiveness of healthcare business bankruptcies while creating tailored policies and procedures that do not impact the rest of the Code.

Scholars and policymakers alike have favored the subchapter concept as a means to incorporate significant changes that better serve particular debtors in the Code. For example, Professor Bruce Markell has advocated for the creation of a separate subchapter for individual chapter 11 debtors.³¹⁷ Separate subchap-

³¹³ See generally *id.* § 1164.

³¹⁴ *Id.* § 1109.

³¹⁵ As an example of a concern about ripple effects, consider executory contracts, which lack a clear definition in the Code. Congress may want to provide clarity about whether provider agreements are executory contracts but may not want this healthcare-specific clarification to impact the interpretation of executory contracts more generally in bankruptcy.

³¹⁶ See *Workouts Forum*, *supra* note 39, at 28 (“[W]hen you come to healthcare there is a unique difference in the language, the technology, the principles, the concepts, [and] the large participation of nonprofit entities in this segment.”).

³¹⁷ See generally Markell, *supra* note 225.

ters already exist in the Code for railroad reorganizations³¹⁸ and stockbroker liquidations.³¹⁹ And recently, Congress passed a law creating a new subchapter for SMEs,³²⁰ recognizing the “unique needs of small businesses” that include the need to reduce unnecessary procedures and the need for a quick reorganization process.³²¹

Creation of subchapters within the Code thus signals congressional intent that certain classes of debtors deserve distinct forms of treatment.³²² Given the significant changes required to address the competing needs of parties in a healthcare provider bankruptcy case, specific subchapters would signal recognition that the administration of a healthcare debtor’s bankruptcy case significantly and substantially differs from that of other bankruptcy cases.³²³

New subchapters within the Code would provide the opportunity for cabined, substantive changes to the Code. Because new Code subchapters can explicitly and directly address concerns with respect to regulators and patients, this proposed change can more thoroughly address the problems currently associated with healthcare provider bankruptcies than further piecemeal changes. Subchapters give healthcare debtors the attention they deserve and consolidate their presence within the Code, which may result in more uniform and more predictable treatment for these debtors in the long run. New subchapters allow bankruptcy law to accommodate differences in healthcare law without a need to rethink the bankruptcy process for other debtors that may not need such accommodation. Finally, new subchapters can better situate regulators and patient representatives within a healthcare provider’s bankruptcy case, thus serving bankruptcy’s broader goals of being responsive to the needs of all parties in interest.

Like any major revision to the Code, this proposal has the potential to impose significant costs as well as major benefits. This proposal may well make the Code more complicated, as existing healthcare provisions are removed and concentrated in entirely new subchapters. Like any new process, bankruptcies under the new subchapters will likely be costly at first, and there is likely to be substantial, short-term uncertainty as to how cases will be resolved.

³¹⁸ 11 U.S.C. §§ 1161–1174.

³¹⁹ *Id.* §§ 761–767.

³²⁰ Small Business Reorganization Act of 2019, Pub. L. No. 116-54, 133 Stat. 1079.

³²¹ *New Bipartisan Legislation to Help Small Businesses Restructure Debt*, AM. BANKR. INST. J., May 2019, at 8; Press Release, Senator Chuck Grassley, Grassley, Bipartisan Colleagues Introduce Legislation to Help Small Businesses Restructure Debt (Apr. 9, 2019), <https://www.grassley.senate.gov/news/news-releases/grassley-bipartisan-colleagues-introduce-legislation-help-small-businesses-0> [<https://perma.cc/8J38-WY5M>].

³²² Markell, *supra* note 225, at 72.

³²³ *Id.*

Nevertheless, the experience of healthcare debtors post-BAPCPA illustrates that reliance on more incremental changes may be misplaced. BAPCPA's healthcare bankruptcy reforms have failed to clear up fundamental inconsistencies in the way that regulators, patients, and creditors interact in a healthcare provider's bankruptcy case. In response to these reforms, many healthcare debtors have sought to resolve their financial distress through alternatives to bankruptcy, which often do not provide adequate debtor protections. Instead of slowly freezing healthcare debtors out of bankruptcy, it is worth considering whether a more holistic revision to the bankruptcy framework is necessary or appropriate.

BAPCPA failed to address many of the key problems with healthcare provider bankruptcies because it failed to recognize explicitly that healthcare debtors should receive distinctly different treatment in bankruptcy than other debtors. By scattering reforms across the Code, BAPCPA also failed to articulate a much-needed organizing principle for healthcare provider bankruptcies. In contrast, healthcare-specific subchapters would link creation of an organizing principle to structural reform within the Code targeted specifically at healthcare debtors.

CONCLUSION

The healthcare industry is on the edge of a severe financial crisis.³²⁴ For many healthcare debtors, bankruptcy has proven a mediocre option at best. Meanwhile, alternatives to bankruptcy do not often provide sufficient debtor protections, lack an organizing principle, and may be difficult to expand. Bankruptcy law could do more to recognize this impending crisis and to fortify the mechanisms available to address it.

This Article suggests that changes to the structure of the bankruptcy system are highly desirable in order to help financially distressed healthcare institutions to "fail better." In particular, the balance of power between the bankruptcy court and healthcare regulators needs to be clarified so that bankruptcy can work in harmony with regulatory goals. To accomplish this end, Congress should consider substantial reforms to the Code, and, in particular, should consider the creation of subchapters specific to healthcare debtors, providing them with much-needed specialized attention. Although the addition of new subchapters risks making the Code more cumbersome and complex, such complexity is warranted given the differences between healthcare institutions and other debtors, the extensive healthcare regulatory backdrop, and the number of

³²⁴ Towery & Watson, *supra* note 288, at 941 ("[I]t appears that more healthcare cases are on the horizon.").

individuals with competing interests present in a healthcare provider bankruptcy case.

On a broader level, the Code is over forty years old. As the Code has been put to the test over the years, scholars, practitioners, and policymakers have recognized that there are many instances where the Code fails to work as intended.³²⁵ This Article has brought attention to one previously underappreciated area where the Code is not serving debtors effectively. As scholars and lawmakers continue to assess the Code, it is worth considering whether the subchapter concept has broader applications to other bankruptcy misfits.

If bankruptcy law and procedure are to serve valuable purposes, the bankruptcy process may well have to change to adapt to the times. Healthcare provider bankruptcies represent one portion of bankruptcies that no longer mirror the process the Code's drafters envisioned in 1978. As discussed, scholars and policymakers are already considering revisions to the Code to address resolutions for distressed financial institutions,³²⁶ and Congress recently created a subchapter for SMEs. But other entities, including bitcoin exchanges,³²⁷ tribal businesses,³²⁸ and nonprofits³²⁹ may also face difficulty when using the Code. This Article therefore suggests that a restructuring of the Code may be needed to ensure that these and other bankruptcy misfits can be accommodated.

Creating new subchapters for healthcare debtors provides an opportunity to assess when and whether further specialization within the Code makes sense. The tradeoffs of increased specialization compared to increased complexity should be considered for many other types of debtors. Healthcare provider bankruptcy reform may represent just a first step in the eventual remaking of the Bankruptcy Code.

³²⁵ Indeed, the American Bankruptcy Institute (ABI) has formed two commissions to study these problems and to make recommendations to reform the Code. See AMER. BANKR. INST., *supra* note 299, at 3 (providing the purpose of the Commission to Reform Chapter 11); *The ABI Commission on Consumer Bankruptcy*, AM. BANKR. INST., <https://consumercommission.abi.org/> [<https://perma.cc/M2RN-XB22>] (describing the Commission on Consumer Bankruptcy).

³²⁶ Pierce, *supra* note 122 (“[T]here has been significant debate as to the most effective—and least disruptive—way to resolve failing financial institutions.”).

³²⁷ See generally Laura N. Coordes, *New Rules for a New World: How Technology and Globalization Shape Bankruptcy Venue Decisions*, 17 *ASPER REV. INT’L BUS. & TRADE L.* 85 (2017).

³²⁸ See generally Laura N. Coordes, *Beyond the Bankruptcy Code: A New Statutory Bankruptcy Regime for Tribal Debtors*, 35 *EMORY BANKR. DEV. J.* 363 (2019).

³²⁹ See *supra* notes 84–87 and accompanying text for a more in-depth discussion of some of these problems.

