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THE MALPRACTICE OF HEALTH CARE BANKRUPTCY REFORM

*Pamela Kohlman Webster**

I. INTRODUCTION

Congress and special interest groups view the Bankruptcy Code the way graffiti artists view a freshly painted wall: neither Congress nor the artist can resist the urge to leave an imprint. Since its enactment in 1978, and despite the years of study and commentary that accompanied its development, the Bankruptcy Code[1] has been frequently and markedly amended by succeeding Congresses.[2] Each amendment created preferences for particular creditors, or limited the options for a particular type of debtor. As with graffiti, whether these additions have enhanced or defaced the Code is subject to considerable debate.

In spite of the stunning failure of the 105th Congress to pass bankruptcy reform legislation prior to its adjournment,[3] the 106th

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1. Act of Nov. 6, 1978, Pub. L. No. 95-598, 92 Stat. 2549 (codified as amended at 11 U.S.C.).

2. Some of the more extensive bills have been the Bankruptcy Amendments and Federal Judgeship Act of 1984, Pub. L. No. 98-353, 98 Stat. 333 (codified in scattered sections of 11 U.S.C. and 28 U.S.C.) [hereinafter 1984 Amendments]; the Bankruptcy Judges, United States Trustees, and Family Farmer Bankruptcy Act of 1986, Pub. L. No. 99-554, 100 Stat. 3105 (codified at 11 U.S.C. and 28 U.S.C.); and the National Bankruptcy Review Commission Act, Pub. L. No. 103-394 §§ 601-702, 108 Stat. 4147 (codified at 11 U.S.C. § 101 (1994)). A list of all federal laws relating to bankruptcy enacted after the Bankruptcy Code through 1994 can be found in Charles Jordan Tabb, *The History of the Bankruptcy Laws in the United States*, 3 AM. BANKR. INST. L. REV. 5, 37 n.266 (1995).

3. On September 23, 1998, the Senate passed Senate Bill 1301, the Consumer Bankruptcy Reform Act of 1998, by a vote of 97-1, a remarkable feat in

Congress has already initiated several attempts to change the Code. This Article examines the recent and future foreseeable efforts to affect health care reform by amending the Bankruptcy Code, and to otherwise affect health care related cases pending under the Code. As discussed below, these efforts are unwise. First, the legislation is poorly drafted and would result in serious unintended consequences. Second, there is no justification for elevating claims of the federal government over the claims of other unsecured creditors. Third, the legislatures' creation of additional duties on bankruptcy trustees appointed in health care bankruptcy cases imposes an unfair burden upon them and an economic penalty on all creditors. The only sensible solution is to require more of the regulators who have the necessary expertise and ability to widely spread the cost.

II. THE BALKANIZATION OF THE BANKRUPTCY CODE

When Congress enacted the Bankruptcy Code, it did not create a law free from special interest considerations or quirky, industry-specific provisions. Special stockbroker and commodity broker liquidations[4] and railroad reorganizations[5] existed. The law has always given beneficial treatment to certain categories of creditors to the exclusion of others equally worthy. Even as enacted, § 507 provided six types of creditors a priority in payment.[6] Section 362 allowed eight exemptions to the automatic stay,[7] and § 523 carved nine types of claims from its discharge provisions.[8]

Over the last twenty years, there has been a steady stream of changes to the Code. These changes have added or broadened provisions favoring a particular group of creditors or burdening, or more rarely benefiting, debtors in a particular industry. Chapter 12 is perhaps the greatest example of how the Code alterations have affected a particular industry.[9] Section 365 now contains multiple examples

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a Congress not particularly well known for its bipartisan spirit. *See* 144 CONG. REC. S10767 (daily ed. Sept. 23, 1998). Despite this lopsided vote, Congress adjourned in October without sending the bill to the President.

4. *See* 11 U.S.C. §§ 741-752, 761-766 (1994).
5. *See* 11 U.S.C. §§ 1161-1174 (1995 & Supp. II 1997 & Supp. III 1998).
6. *See* 11 U.S.C. § 507 (1994).
7. *See id.* § 362(b).
8. *See id.* § 523.
9. *See id.* §§ 1201-08, 1221-31.

of creditor favoritism.[10] Section 507's priority classes have grown to nine to include grain growers, fishermen,[11] and recipients of alimony and child support.[12] Each of Section 523's exceptions to discharge and Section 362's exceptions to the automatic stay have grown to eighteen.[13] At times, Congress has simply added whole sections to the Code in order to benefit an insular group of politically active creditors. Examples include § 1113,[14] which creates considerable roadblocks to an employer's ability to reject a collective bargaining agreement,[15] and § 1114,[16] which makes it extremely difficult to modify a retiree's benefits in a Chapter 11 case.[17]

III. THE HEALTH CARE INDUSTRY AND BANKRUPTCY CODE "REFORM"

Recent efforts to affect health care related bankruptcy cases have only perpetuated the rending pattern of the last twenty years. These efforts fall into the same two broad types found in earlier amendments: Those changes that attempt to negate the impact of health care related bankruptcy cases on particular creditors, in this instance the federal government, and those that impact how a health care concern in bankruptcy is liquidated or reorganized. Each type is discussed and separately criticized below.

A. The Government Protecting the Government

Under the Social Security Act,[18] qualified health care providers receive periodic estimated payments for covered Medicare and

10. *See id.* § 365. Since creating the Section, Congress has changed it at the behest of real and personal property lessors—particularly shopping center lessors—intellectual property licensees, airport operators, and timeshare interest buyers.

11. But only if they are United States fishermen. *See* 11 U.S.C. § 507(a)(5)(B).

12. *See id.* § 507(a)(7).

13. *See id.* §§ 523(a), 362(b).

14. Section 1113 was added as part of the 1984 Amendments. *See* 11 U.S.C. § 1113 (1984), 98 Stat. 390 (July 10, 1984).

15. *See id.*

16. Section 1114 was added as part of Act of Nov. 3, 1988, Pub. L. No. 100-334, § 2(a), 102 Stat. 610 (June 16, 1988).

17. *See* 11 U.S.C. § 1114 (1994).

18. 42 U.S.C. § 301 (1994).

Medicaid services from the Department of Health and Human Services ("HHS").[19] Annually, HHS reconciles the total amounts paid with the proper amounts due and compensates the provider for any previous underpayment.[20] Any overpayments are recovered through deductions from future reimbursements.[21] HHS can also suspend payments if it believes that the provider has committed fraud or willful misrepresentation, has failed to file reports, or otherwise has failed to meet the proper standard of care established for Medicare providers.[22]

Many health care providers' daily operations are dependent upon Medicare or Medicaid funding. Any interruption in the flow of funds, therefore, can precipitate a financial crisis and force a bankruptcy filing.[23] The bankruptcy filing raises concerns that HHS will not be able to recover the overpayment because of the automatic stay[24] or may have to give back what it recovered as a preference.[25]

Although the early days of the 106th Congress were not noteworthy for the attention given to legislative matters, Congress at least gave some attention to making the overpayment claims less of a concern to the government in the event of a bankruptcy filing by the provider. On January 20, 1999, Senator Charles Grassley,[26] who frequently sponsors bankruptcy legislation, and Senator John Breaux,[27] who is active in health care issues, introduced Senate Bill 255, the "Home Health Integrity Preservation Act of 1999."[28] Although Senate Bill 255 does not primarily focus on bankruptcy,[29] bankruptcy

19. *See* 42 C.F.R. § 413.64(b) (1997).
20. *See* 42 U.S.C. § 1395g(a) (1994).
21. *See* 42 C.F.R. § 413.64(f) (1997).
22. *See id.*
23. *See* Samuel R. Maizel & Judith A. Waltz, *Injunctive Relief in Health Care Insolvencies*, 24 CAL. BANKR. J. 215 (1998).
24. *See* 11 U.S.C. § 362(a) (1994). The automatic stay is an injunction that arises immediately upon the commencement of the bankruptcy case. It prohibits a wide range of activity to collect pre-bankruptcy debts or to assert or enforce claims against the debtor's property.
25. *See* 11 U.S.C. § 547 (1994). Section 547 permits the avoidance of transfers made in the ninety days—or, in the case of insiders, one year—before bankruptcy that gives the creditor an advantage. *See id.*
26. Charles Grassley is a Republican Senator from Iowa.
27. John Breaux is a Democratic Senator from Louisiana.
28. S. 255, 106th Cong. (1999).
29. The bill purports "[t]o combat waste, fraud, and abuse in payments for

is at least on the sponsors' minds. In his remarks, Senator Grassley stated that the purpose of the Act is "to make it harder for all Medicare providers, not just home health agencies, to avoid penalties and repayment obligations by declaring bankruptcy."[30]

Senate Bill 255 impacts a bankruptcy case in three significant ways.[31] First, it exempts from the automatic stay "any action against a [Medicare provider], including any action or proceeding to exclude or suspend such debtor from program participation, assess civil monetary penalties, recoup or set off overpayments, or deny or suspend payment of claims."[32] Second, it makes an obligation on account of a Medicare overpayment and related penalties, fines, and assessments non-dischargeable.[33] Finally, it makes unavoidable any otherwise preferential payments made by a Medicare provider.[34]

Among its other problems, and despite the significance of these changes to the Bankruptcy Code, Senate Bill 255 does not actually seek to amend the Code itself. Instead, these special provisions are to be added to Titles XI and XVIII of the Social Security Act.[35]

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home health services provided under the Medicare program, and to improve the quality of those home health services." *Id.*

30. 145 CONG. REC. S750, S756 (daily ed. Jan. 20, 1999) (statement of Sen. Grassley).

31. The bill's bankruptcy provisions are similar to those proposed in the Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997, proposed by the Clinton Administration, and the Medicare Fraud and Overpayment Act introduced in 1998 in the House as House Bill 3471 and in the Senate as Senate Bill 1788. Neither was enacted. *See* H.R. 1770, 105th Cong. (1997); H.R. 3471, 105th Cong. (1998); S. 1788, 105th Cong. (1998).

32. S. 255, 106th Cong. § 9(a) (1999). One can only hope that the "any action" language will be clarified in the legislative process. As written, it eliminates entirely the automatic stay against any creditor action in a health care related bankruptcy case.

33. *See id.* § 9(b).

34. *See id.* § 9(c). Although Senate Bill 255 does not make a claim arising from a Medicare overpayment a priority claim under Section 507, such an effort is anticipated. Making the claim non-dischargeable is meaningless in most health care cases since few with significant Medicare overpayment claims are operated as sole proprietorships, and only individuals are entitled to a discharge.

35. 42 U.S.C. §§ 1301-1320c-22, 1395-1395ccc (1994).

B. Restrictions on Health Care Debtors and Trustees

Senate Bill 625[36] provides the best example of a legislative proposal that seeks to create special operational rules in a health care provider's bankruptcy case. Senate Bill 625, introduced on March 16, 1999, by Senator Grassley is entitled the "Bankruptcy Reform Act of 1999."[37] Although Senate Bill 625 has many provisions,[38] health care provisions occupy one of its thirteen titles. If enacted, the bill will make health care a unique type of bankruptcy case.

Senate Bill 625 first defines a health care business as any profit or non profit public or private entity, that is primarily engaged in offering to the general public facilities and services for the diagnosis of injury, deformity, or disease, or provide surgical, drug treatments, psychiatric or obstetric care.[39] These facilities specifically include a hospital, hospice, health maintenance organization, long-term facility or home for the aged. Other defined terms included health maintenance organizations, patients, and patient's records.[40]

Section 1102 of the Bill would add a new section 351 to the Bankruptcy Code that would contain specific provisions for the disposal of patient records in a bankruptcy case.[41] Generally, if the estate lacks sufficient funds to pay for the storage of patient records, the bill obligates the trustee to request permission to deposit the records with the "appropriate" federal or state agency.[42] If the government or agency refuses or fails to respond within sixty days, then the trustee is obligated to publish a notice in the "appropriate" newspaper that the records will be destroyed if not claimed by the patient's

36. S. 625, 106th Cong. (1999). The bill's provisions are similar to those proposed in the "Business Bankruptcy Reform Act," which Senator Grassley proposed in the 105th Congress as Senate Bill 1914.

37. *See id.* §1(a).

38. Among other things, Senate Bill 625 limits consumer access to Chapter 7 bankruptcy cases and provides for a special small business bankruptcy case; adds a Chapter 6 to the Bankruptcy Code to govern ancillary and cross-border bankruptcy cases; modifies or adds provisions dealing with financial instruments such as forward contracts and swap agreements; and addresses various bankruptcy tax issues. *See* S. 625, 106th Cong. (1999).

39. *See id.* § 1101(a).

40. *See id.* § 1101(b)-(d).

41. *See id.* § 1102(a).

42. *See id.*

insurance provider.[43] In addition, the trustee is required to attempt to notify each patient directly.[44] If there is still no response, the trustee is required to shred, burn, or otherwise destroy the records.[45]

Section 1103 of the Bill would modify § 503(b) of the Bankruptcy Code to add, as a new administrative expense, the actual and necessary costs and expenses of closing a health care business including the required manner of disposing of patient records and transferring patients.[46]

Section 1104 of the Bill would add a new section 332 to the Bankruptcy Code, which would require the appointment of an ombudsman within thirty days of the commencement of any health care bankruptcy case to act as a patient advocate.[47] The duties of such an ombudsman would be to monitor the quality of patient care and report to the court not later than every sixty days regarding the quality of patient care. If the ombudsman believes that the quality of patient care is declining significantly or is otherwise being materially compromised, he or she must report to the court immediately upon making that determination. Compensation of the ombudsman is to be at the expense of the estate.[48]

Finally, Section 1105 of the Bill would add to the duties of a trustee a requirement that he or she use all "reasonable and best efforts" to transfer patients from the health care business debtor being closed, to a health care business or other entity in the same general vicinity that provides substantially similar services and maintains a reasonable quality of care.[49]

Less recently, on February 2, 1999, Representative Mike Bilirakis[50] introduced the "Patient Protection Act of 1999," which hasbeen numbered House Bill 448.[51] Like Senate Bill 625, House Bill

43. *See id.*
44. *See id.*
45. *See id.*
46. *See id.* § 1103.
47. *See id.* § 1104.
48. *See id.*
49. *See id.* § 1105.
50. Mike Bilirakis is a Republican Representative from Florida.
51. H.R. 448, 106th Cong. (1999).

448 deals with a number of other matters, although, unlike Senate Bill 625, they are all at least related to health care.[52]

Section 810[53] of House Bill 448 includes language that would allow the Secretary of HHS to petition the district court to be named trustee of an insolvent group health plan for the duration of the insolvency if the plan is "unable to provide benefits when due or is otherwise in a financially hazardous condition."[54] The application may be filed by the Secretary notwithstanding any pending bankruptcy petitions and the existence of the automatic stay.[55] In fact, once the application is filed, the district court has exclusive jurisdiction over the health group plan and must stay the bankruptcy proceedings pending its decision.[56]

Under the proposed legislation, the district court is obligated to make the appointment "if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan."[57] If appointed, the Secretary would have the same duties as any Chapter 7 trustee[58] in addition to other duties as set forth in the legislation.[59] House Bill 448 is, however, otherwise silent as to how the insolvency case would be administered.

Representative Charles W. Norwood, Jr.[60] introduced similar legislation, entitled the "Affordable Health Care Act of 1999,"[61] on

52. Among other things, this lengthy legislation provides for: unrestricted access to certain medical care, grievance procedures, patient access to information, and limits patients' damages in the event of litigation.

53. Section 810 is found in Section 1302(a) of House Bill 448 and amends subtitle B of Title I of the Employee Retirement Income Security Act of 1974.

54. H.R. 448 § 1302(a) (adding section 810(a) to subtitle B of Title I of the Employee Retirement Income Security Act of 1974).

55. *See id.* (adding section 810(e) to subtitle B of Title I of the Employee Retirement Income Security Act of 1974).

56. *See id.* (adding section 810(f)(1) to subtitle B of Title I of the Employee Retirement Income Security Act of 1974).

57. *Id.* (adding section 810(a) to subtitle B of Title I of the Employee Retirement Income Security Act of 1974).

58. The duties of a Chapter 7 trustee are provided in 11 U.S.C. § 704.

59. *See* H.R. 448 § 1302(a) (adding section 810(d) to subtitle B of Title I of the Employee Retirement Income Security Act of 1974).

60. Charles Norwood is a Republican Representative from Georgia.

61. H.R. 1136, 106th Cong. (1999).

March 16, 1999. House Bill 1136, among other things,[62] seeks to provide affordable health care through the creation of association health plans.[63] House Bill 1136 provides that whenever the Secretary of HHS determines that an association health plan is in a financially hazardous condition, the Secretary may apply to the district court to be appointed as the plan's trustee to administer it during the period of its insolvency.[64] The provisions in House Bill 1136 concerning jurisdiction, standards for appointment, and duties of the Secretary are identical to the provisions of House Bill 448.[65] As with House Bill 448, there are no other provisions discussing how the insolvency case is to be administered.

Congress is not alone in its attempts to dictate the administration of a health care bankruptcy case. In 1998, the California legislature added section 1421.5 to its Health and Safety Code.[66] It dictates certain notices that must be provided to the State Department of Health Services in the event of the commencement of a bankruptcy case involving a long-term health care facility.[67] Further, it requires a bankruptcy trustee to comply with all state licensing and federal certification requirements applicable to a long-term health care facility, including those governing patient rights, transfer or discharge, and facility closings.[68] In two separate places, section 1421.5 declares that the trustee must be notified when the transfer of patients presents a compelling public health and safety risk, and that the trustee is not exempted from complying with applicable state law "for any reason."[69]

62. House Bill 1136 also authorizes multi-employer HealthMarts, establishes refundable credits for providers of qualified health coverage, and enhances the availability of medical savings accounts. *See id.*

63. House Bill 1136 defines association health plans as group health plans organized by trade, profession, and industry association, or by chambers of commerce. *See id.* § 801.

64. *See id.* § 810(a).

65. *See id.* § 810(d)-(f).

66. *See* CAL. HEALTH & SAFETY CODE § 1421.5 (West Supp. 1999).

67. *See id.* § 1421.5(a)(1), (a)(2).

68. *See id.* § 1421.5(a)(3)(A).

69. *Id.* § 1421.5(a)(3)(B), (b)(1).

C. Back to the Drawing Board

As suggested above, the health care bankruptcy reform legislation of the type introduced in Congress and enacted by the California legislature reflects poor drafting. Seeking to change the Bankruptcy Code by amending the Social Security Act as Senate Bill 255 does defy common sense. Resorting to another federal or state law destroys the textual benefit of the Bankruptcy Code as unified legislation. In addition, Senate Bill 255's waiver of the automatic stay against "any action" would be a disaster. Further, House Bills 448 and 1136 fail to incorporate by reference those provisions of the Bankruptcy Code necessary for a sensible liquidation.

Better crafting of the proposed amendments is not an adequate answer to the problems raised by much of the insolvent health care provider legislation. These efforts to amend the Bankruptcy Code, or otherwise restrict the administration of a bankruptcy case, largely reflect bad policy that no amount of rewriting will cure.

IV. WHAT IS WRONG WITH THE GOVERNMENT PROTECTING ITS COFFERS

No one doubts that Congress could redraft the Code to favor the federal government over all other creditors. The relevant inquiry is not whether Congress can, but whether it should. The answer should be a resounding "No." One of the fundamental policies of bankruptcy law is the equal treatment of creditors.[70] Upon the commencement of a bankruptcy case, creditors are compelled to halt their individual collection efforts in favor of a collective remedy.

Implementing this important policy requires limits on the amount and scope of priority claims.[71] Notwithstanding the rare case of a solvent estate, priority claims diminish, if not destroy, the unsecured creditors' distribution. Thus, the greater the number and amount of priority claims, the more unequal the treatment of creditors.[72]

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70. *See* COMMISSION ON THE BANKRUPTCY LAWS OF THE UNITED STATES, REPORT OF THE COMMISSION ON THE BANKRUPTCY LAWS OF THE UNITED STATES, H.R. REP. NO. 93-137, pt. 1, at 17 (1973).

71. Priority claims are those which must be paid in full before other unsecured creditors receive any distribution.

72. An equally fundamental policy of the Bankruptcy Code is the ability of

What supports the federal government receiving a priority claim in a health care bankruptcy case for Medicare overpayments? Support is not in the Bankruptcy Code itself. Indeed, the policy of the Code seems to suggest that the government should be treated as any other creditor except in the narrowest of circumstances. Section 106 of the Code includes governmental units[73] in its definition of creditors and, for the most part, provides that governmental units are to be treated like any other creditor.[74] Section 106 waives the federal government's sovereign immunity and allows its claims to be treated like other claims, subject to avoidance, setoff, and other defenses.[75] Bankruptcy courts are specifically given the jurisdiction to enter final orders and judgments for monetary, declaratory, and injunctive relief, other than punitive damages, against the United States.[76]

Although the Code gives an eighth priority for certain tax claims,[77] that priority cannot be explained solely as a governmental protection program, which would be true for Medicare overpayment claims. First, priority taxes are also non-dischargeable.[78] The greater the distribution to the government on its priority claim, the less the debtor will have to pay post-discharge. The Code's preference for federal tax claims over general unsecured claims, therefore,

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the honest debtor to obtain a new financial life through the discharge of unpaid debts. This is often called a debtor's "fresh start." *See* H.R. REP. NO. 95-595, at 384 (1977), *reprinted in* 1978 U.S.C.C.A.N. 5963, 6340; S. REP. NO. 95-989, at 98 (1978), *reprinted in* 1978 U.S.C.C.A.N. 5963, 6059. Increasing the number and scope of non-dischargeable claims, as Senate Bill 255 does for Medicare overpayment claims, harms the fresh start in the same manner as increasing priority claims does for the equal treatment of creditors.

73. The definition of a "governmental unit" includes the United States and any state, commonwealth, district, territory, municipality, foreign state, department, agency or any instrumentality of the United States, or any other foreign or domestic government. *See* 11 U.S.C. § 101(27) (1994).

74. *See* 11 U.S.C. § 106(a)(3) (1994).

75. *See id.* § 106(c).

76. *See id.* § 106(a)(3).

77. A ninth priority is reserved to "allowed unsecured claims based upon any commitment by the debtor" to a federal depository institution. Crime Control Act of 1990, Pub. L. No. 101-647, 104 Stat. 4789, 4867 (1990). Like the Medicare crisis of current days, Congress in 1990 was concerned with the impact of the savings and loan bailout on the treasury. Its enactment suffers from the same poor policy as a Medicare overpayment priority would suffer today.

78. *See* 11 U.S.C. § 523(a)(1) (1994).

benefits the competing bankruptcy policy of protecting the debtor's fresh start.[79]

One additional justification for treating tax claims differently is that they are involuntary claims. The government does not pick and choose who owes it taxes. It should not, therefore, be subject to the same risk of non-payment as voluntary creditors are.[80] It is unclear why other involuntary creditors, such as tort victims, who also do not elect to be creditors of a debtor, are not also given a priority in payment. But even if involuntariness is a valid justification, it would have little application in the health care context because the federal government does choose with whom to do business. In order to participate in the Medicare program, a provider must be qualified by HHS.[81] In other words, the federal government assumes a risk of non-payment with a health care provider in the same manner any trade creditor assumes a credit risk.

In addition to the federal government's ability to bear the loss better than most unsecured creditors, the government already has a powerful collection of tools to use against an insolvent health care provider who has received Medicare overpayments. These existing rights make the proposed legislation somewhat unnecessary. Although the Code recognizes a creditor's right of setoff in all cases, except for limited, abuse-prone situations,[82] setoff requires that the creditor's claim and the creditor's debt both arise pre-petition.[83] Yet, in the health care arena, courts have allowed Medicare overpayments received by a debtor pre-petition to be subtracted from payables due to the debtor in possession by invocation of the equitable doctrine of

79. *See* S. 255, 106th Cong. § 9(a) (1999). While the same could be true of Medicare overpayment claims, since Senate Bill 255 seeks to also make them non-dischargeable, the distinction turns on the identity of the debtor. As discussed at *supra* note 34, dischargability is irrelevant except in a bankruptcy case of an individual. Virtually all individual debtors are subject to tax claims. Few individual debtors are subject to large Medicare overpayment claims.

80. *See* H.R. REP. NO. 95-595, at 190 (1977), *reprinted in* 1978 U.S.C.C.A.N 5963, 6150.

81. The Social Security Act requires that a health care provider meet certain statutory criteria and file a provider agreement with HHS. *See* 42 U.S.C. § 1395cc(a) (Supp. V 1988).

82. *See* 11 U.S.C. § 553 (1994).

83. *See id.* § 101(5)(B).

recoupment.[84] In addition, it is the position of both the Fifth Circuit and HHS that a company that purchases a medical provider's assets, including its Medicare provider agreement, assumes liability of any past overpayments made by HHS to the predecessor provider.[85] Unless a health care provider ceases operations and abandons its license, the Medicare overpayments will eventually be repaid.

Finally, there may be a place for the equitable doctrine of unclean hands in this controversy. At least some of the fault for the financial turmoil in the health care industry should be laid at the feet of the federal government.[86] Projections show the Medicare Trust Fund running out of cash in the next century.[87] To date, the government has opted merely to pay less for the services provided, rather than reducing benefits or beneficiaries.[88] The Balanced Budget Bill of 1997,[89] for example, reduced payments to providers by $115 billion over five years by reducing reimbursements for managed care and reductions in hospital payments.[90] Thus, it should not be surprising that the number of health care insolvencies has increased by ten to fifteen percent per year for each of the last three years.[91] Having caused a problem that hurts all creditors, the federal government should not be allowed to save only itself from the damage.

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84. *See, e.g.*, United States v. Consumer Health Servs. of Am., Inc., 108 F.3d 390 (D.C. Cir. 1997). *But see* University Med. Ctr. v. Sullivan (*In re* University Med. Ctr.) 973 F.2d 1065 (3d Cir. 1992). Unlike setoff, recoupment is not mentioned in the Bankruptcy Code. It is a creditor's right to deduct a debt it owes to the debtor from a claim it has against the debtor, so long as the reasons for the reduction arise out of the same transaction or occurrence. *See* University Med. Ctr., 973 F.2d at 1079-80.

85. *See* United States v. Vernon Home Health, Inc., 21 F.3d 693, 695-96 (5th Cir. 1994).

86. Donna D. Fraische, *The Interrelationship Between Bankruptcy and Health Care Law*, paper presented to the Chapter 11 Subcommittee of the Business Bankruptcy Committee of the Business Section of the American Bar Association, October 24, 1998.

87. Samuel R. Maizel, *A New Look at Healthcare Restructuring*, paper presented to the Chapter 11 Subcommittee of the Business Bankruptcy Committee of the Business Section of the American Bar Association, October 24, 1998.

88. *See id.*

89. Pub. L. No. 105-33, 111 Stat. 251 (1997).

90. *See id.*

91. *See* Nancy A. Peterman, *Protecting Patients' Rights in Health Care Bankruptcies*, AM. BANKR. INST. J., Sept. 1998, at 10.

V. HEALTH CARE CASES SHOULD NOT BE SUBJECT TO SPECIAL BANKRUPTCY RESTRICTIONS

Perhaps it is inevitable that health care is the focus of Bankruptcy Code revision. After all, health care has already been the subject of substantial legislative and regulatory attention. Moreover, this attention has only increased as a greater percentage of the federal budget is devoted to Medicare, Medicaid, and veteran benefits programs. The United States spends more money on health care than any other nation.[92] It is not surprising that the scope of those statutes and regulations may now extend to what happens to health care concerns in bankruptcy. Perhaps health care should be treated differently from bankruptcy because it is fundamentally different. Adequate health care has been declared to be a fundamental right.[93] What other industries filing for bankruptcy provide fundamental rights?

It is also difficult for Congress and the states to not react to horror stories like health care insolvencies. For example, imagine a cancer patient arriving at a clinic for treatment only to find the door chained, her medical records having been thrown out by a landlord who has retaken possession of a closed facility. Imagine receiving a call late one night telling you that you must move your fragile mother to a new facility by morning.[94]

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92. *See* Maizel, *supra* note 87, at 1.

93. *See* President's Remarks to the Montgomery County Community in Norristown, Pa., 35 WEEKLY COMP. PRES. DOC. 95 (Jan. 20, 1999).

94. The enactment of California Health and Safety Code Section 1421.5 was prompted by a bankruptcy trustee's relocation of nursing home residents two days after his appointment. *See* Martha L. Willman, *Bill to Bar Evictions at Nursing Homes Okd: The Measure, Prompted by an Incident in Which Residents of a Failed Reseda Facility Were Kicked Out, Awaits Governor's Final Signature*, L.A. TIMES, Aug. 19, 1998, at B1. Prior to the enactment of Section 1421.5, California law had required thirty days' notice before the closure of a health facility. However, the notice requirement only applied to licensed health care operations, but not to trustees acting in bankruptcy. Thus, the trustee who had inherited a facility lacking food or supplies immediately ordered the eviction of the facility's patients. Since removing or disrupting patients in a disorderly manner potentially endangered the patients' lives, following California law prior to 1421.5 was more dangerous to them than a more organized relocation would have been. *See id.*

These situations are grim and cry out for a solution. However, amending the Bankruptcy Code to dictate how they must be run is not that solution. If a health care provider has commenced a bankruptcy case, chances are that it has been in financial straits for some time. Whether those financial straits have been caused by governmental policies or not, better regulatory oversight might have prevented the problem from even beginning. Likewise, oversight can forestall difficulties from becoming so severe as to require a bankruptcy filing. As discussed above, providers are often forced to file bankruptcy because HHS has frozen their Medicare payment stream. If HHS wants to eliminate the problem of health care providers in bankruptcy, a more cooperative approach with the providers may be all that is necessary.

Even if better oversight would not have prevented the bankruptcy case, the proposed amendments to the Bankruptcy Code and the Social Security Act would be unworkable solutions in Chapter 7 cases. Senate Bill 625 and California Health and Safety Code section 1421.5 rest the whole weight of avoiding unacceptable upheaval on bankruptcy trustees. Bankruptcy trustees are typically lawyers and accountants without specialized health care expertise. Trustees are charged with evaluating the services and care quality of replacement facilities, determining the appropriate regulatory agency for the storage of records, and otherwise moving patients and preserving their records. Accomplishing these tasks is very difficult without expertise.

Further, how is a bankruptcy trustee to perform these duties without adequate funding? A closed facility likely has no liquid assets. The receivables may be pledged to a factor or subject to a Medicare overpayment recoupment claim. Who is going to pay for the storage, notices and patient transfers the trustee must provide? What trustee will accept an assignment that dictates responsibilities but provides no means to pay for the exercise of those responsibilities except out of the trustee's own pocket? The only sensible solution is making patient records and patient transfers the responsibilities of the appropriate federal, state, and local agencies. The agencies have the expertise in health care and other related patient matters, and the ability to spread the cost among all taxpayers.

Some of the same problems exist with Senate Bill 625's creation of the office of ombudsman. To have an ombudsman in a liquidation case is meaningless. As a practical matter, by the time the ombudsman is appointed, the facility will have been long closed. There is no need for a patient advocate when there are no patients. Again, who will pay for this additional administrative layer?

There may be more justification in a Chapter 11 case, in which the debtor is operating as a debtor in possession. However, it is difficult to understand what an ombudsman would do that we should not expect of the regulatory agencies with oversight responsibility for all health care providers. If we are to have federally mandated patient advocates, then let us have them in all situations and have the cost borne by the public as a whole rather than alone by the unsecured creditors of a particular health care provider.

There remains, then, Representatives Bilirakis and Norwood's idea to allow the Secretary of HHS to be a bankruptcy trustee. The idea is a beneficial one in a liquidation case but the legislation is too limiting. House Bills 448 and 1136 only concern certain types of health plans. They should be expanded to cover all health care providers regulated by HHS. Further, since the Secretary must petition to be appointed, the legislation is limited to those situations in which the Secretary chooses to act. For the expertise and expense reasons discussed above, the bills should be expanded to require the Secretary to serve as a Chapter 7 trustee for all regulated health care providers in which a panel Chapter 7 trustee is unwilling to act.

Finally, House Bills 448 and 1136 should remove the district court from the proceedings. Bankruptcy courts are far more experienced in ascertaining the circumstances in which a trustee should be appointed as well as all other matters relevant to the liquidation or reorganization of an enterprise.

VI. CONCLUSION

Successful legislation affecting health care bankruptcies is all but certain in the 106th Congress. The sheer number of bills left at the end of the last Congress, coupled with the bills introduced in the early days of the first session of the 106th Congress, make the closing of another Congress without substantial Bankruptcy Code amendments unlikely. Unfortunately, health care bankruptcy cases

and health care fraud are inextricably linked in the minds of Congress.

But, if Congress can refrain from overreacting to abuse cases, all need not necessarily be lost to bankruptcy purists. Congress should preserve the fundamental policies of equal treatment of creditors, as well as preserve a debtor's fresh start, and recognize that bankruptcy trustees have neither the expertise nor the financing to solve the problems of a financially destroyed health care provider and its patients. With the understanding that better inspections, oversight, and cooperation of those with the expertise and resources can eliminate the problems encountered, the integrity and the benefits of the Bankruptcy Code will be better preserved.