

The \$363 Miracle Drug?

Potential Restrictions and Challenges of Selling Hospitals in Bankruptcy

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Editor's Note: Please refer to the *Intensive Care* article featured in the September 2009 Journal, which also discussed selling health care assets in bankruptcy. The September article concentrated more on the health care law, whereas this article focuses on the interplay between bankruptcy considerations and other statutory and regulatory restraints and requirements.

As the Obama administration attempts to address health care reform, it should be clear that America's hospitals and hospital systems are also facing an economic crisis and are not as recession-proof as people once believed.¹ Moreover, the 363 sale solution pursued by most corporations as the quick-fix bankruptcy route (*à la* Chrysler and General Motors) may not be the cure-all for most ailing hospitals.



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The hospital industry in large part is not driven by corporate profits or return to stakeholders. About 60 percent of the 3,400 hospitals in the United States are nonprofit, 23 percent are for-profit and another 17 percent are run by counties, states or the federal government. Over time, this mix of religious, governmental and community missions has created an industry that tolerates excess capacity and corporate inefficiencies that would be unheard-of in rational economic markets.² Thomson Reuters reported that half of all U.S. hospitals lost money in 2008.³ Standard & Poor's has not raised its rating on any

¹ See Samuel R. Maizel, Shane Passarelli and George D. Pillari, "The Financial Crisis Facing America's Hospital Industry: Part I," *ABI Journal*, Vol. XXVII, No. 10, December/January 2009.

² For more financial analysis and findings regarding hospital insolvencies, see Alvarez & Marsal Healthcare Industry Group, "Hospital Insolvency: The Looming Crisis" available at www.alvarezandmarsal.com/en/global_services/healthcare/resources/documents/AM_HospitalStudy.pdf (April 2008).

³ See Jason Roberson, "Hospital Finances Showing a Rebound," *The Dallas Morning News*, Aug. 18, 2009, available at www.dallasnews.com.

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hospital system in the past year, not even on nonprofit hospitals.⁴ There were 107 lowered ratings for the nonprofit health care sector, which includes stand-alone hospitals and systems, in 2008 through June 1 this year.⁵ There are only so many hospital programs or people that can be cut, and patient care requirements impose unique restructuring restrictions.



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At especially high risk are those hospitals and other health care facilities that rely on philanthropic contributions, and hospitals facing rising debt due to issues associated with uninsured patients,

in its market, or in a nearby market and vertical integration where physicians, hospitals and others engage in various types of combinations.

For struggling hospitals looking to address financial challenges, bankruptcy continues to be a restructuring option, and it appears to be on the rise.⁷ Although a bankruptcy filing may be inherently unpredictable and expensive, the breathing space often provided by the automatic stay and the benefits of §§363 and 365 of the Bankruptcy Code make chapter 11 (or chapter 9 for governmental entities) the best way to evaluate a hospital's restructuring alternatives and to accomplish a sale. Nevertheless, it is important to understand that a proposed hospital reorganization under title 11 is fraught with a unique set of challenges and complexities.

Can and Should a Hospital File for Bankruptcy?

Since the vast majority of hospitals are nonprofit or government-operated, it is important to be aware of the potential restrictions and nuances that come into play when a hospital is not a for-

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whose numbers continue to increase in correlation with rising unemployment rates. In addition, public hospitals are in poor financial health not only because the tax-raising municipalities they rely on for funds, like counties, are facing a host of pressures, but because state Medicaid programs are strapped for cash. Consequently, Medicaid reimbursement is getting stingier.⁶

With all this distress, opportunity awaits the financially healthier hospitals and the appropriate investors. Consolidation is common in today's health care industry, taking multiple forms, including the growth of hospital systems through acquisitions and mergers, local market acquisitions where a single hospital acquires another

profit institution. As an initial matter, a hospital, either nonprofit or for-profit, may be a debtor under §109 of the Bankruptcy Code and may file for relief under chapter 11.⁸ However, a nonprofit hospital, pursuant to §303(a), is freed from the threat of being involuntarily placed into bankruptcy. A public hospital may not qualify for relief under chapter 11, but may file for relief under chapter 9.⁹ However, state law

⁷ There were 30 health care-related bankruptcies filed in the first quarter of 2009, up from 16 and 14 for the same periods in 2008 and 2007, respectively. The four largest health care bankruptcies filed so far in 2009 were filed in the first quarter: Forum Health (with \$100 million in assets), Caritas Health Care Inc. (\$87.2 million), St. Mary's Hospital in Passaic, N.J., and Wadley Regional Medical Center (both with \$50 million in assets). See Chelsey Franks, "Caregivers Now in Need of Care," *The Deal Pipeline*, June 12, 2009, available at <http://pipeline.thedeal.com>.

⁸ When state insurance regulators have challenged the eligibility of HMOs for bankruptcy protection, the courts have generally found that HMOs are domestic insurance companies and may not be debtors under §109(b). See *In re Portland Metro Health Inc.*, 15 B.R. 102 (Bankr. D. Ore. 1981); *In re Beacon Health Inc.*, 105 B.R. 178 (Bankr. D. N.H. 1989).

⁹ See, e.g., *In re Heffernan Memorial Hosp. Dist.*, 192 B.R. 228, 230 (Bankr. S.D. Cal. 1996).

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may impede a nonprofit hospital from seeking to reorganize (or liquidate) under the Code. As creations of state law, nonprofits are confined to limitations imposed by state law. Some states may not permit their nonprofit corporations to file for bankruptcy, but instead providing detailed procedures for receivership or other state liquidation procedures to be overseen by state courts.

Nonprofit corporations and public corporations (e.g., municipal hospitals) have no private owners, and no private person is entitled to benefit from their profits and increased value. The nonprofit hospital corporation must use its profits to further only the corporation's purposes, which typically are established within the hospital's "mission statement." Consequently, in addition to the traditional duty of care and duty of loyalty that govern a board's actions, nonprofit boards must also be aware of the duty of obedience to their facilities' charitable missions, which obligate directors to further the charitable purposes of their organization.

When dealing with a nonprofit hospital, a professional must become familiar with the state's nonprofit corporation law, as well as obtain a copy of the hospital's mission statement to ensure that the chosen bankruptcy strategy conforms with the entity's purpose and goals. The hospital's mission and the board's duties may impact whether a hospital should file for bankruptcy and the lens through which any sale will be viewed.

Bankruptcy Code Limitations on Selling Hospital Assets and Assigning Contracts

On account of the inherent limitations on restructuring the operational "business" of the hospitals, one of the most common goals of a hospital chapter 11 filing is the pursuit of a partial or complete sale of assets. In the normal corporate context, a bankruptcy sale provides the added benefit of avoiding many limitations of state law (e.g., *ipso facto* clauses or going-out-of-business sale guidelines) and obtaining the highest and best price. The availability and benefits of a §363 sale have made chapter 11 the strategy of choice for many debtors. However,

to the extent a hospital is a nonprofit corporation, the Code has limitations on the debtor's ability to sell free of state law restrictions.

Section 363(d) was amended by Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) to provide that a trustee may use, sell or lease property of the bankruptcy estate "only in accordance with applicable nonbankruptcy law that governs the transfer of property by a corporation or trust that is not a moneyed, business or commercial corporation or trust."¹⁰ The limited legislative history indicates that the effect of this amendment was "to restrict the authority of a trustee to use, sell, or lease property by a nonprofit corporation or trust."¹¹

Similarly, §1129(a) was amended by BAPCPA to provide for confirmation of a chapter 11 plan only if all transfers of property are "made in accordance with any applicable provisions of nonbankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust."¹² The legislative history, making reference to the amendment to §363(d), states that this amendment "imposes similar restrictions with regard to plan confirmation requirements for chapter 11 cases."¹³ Lastly, BAPCPA amended §541 of the Code to provide that notwithstanding any other Code provision, property held by a debtor that is a 501(c)(3) corporation may be transferred to an entity that is not such a corporation "only under the same conditions as would apply if the debtor had not filed a case under [the Bankruptcy Code]."¹⁴

These three amendments limit a nonprofit hospital debtor's ability to sell its assets free and clear of, or assign contracts free of, any regulatory or other nonbankruptcy law restrictions. For example, the Hill-Burton program is a federal loan and grant program for the construction or modernization of nonprofit and public health care facilities.¹⁵ Among other requirements, recipients of Hill-Burton funds are

required to provide uncompensated care for either 20 years or perpetually, and to provide community service, including participation in Medicare and Medicaid. If the facility, within 20 years of construction/modernization, is (1) sold or transferred (including through a bankruptcy) to an entity that is not qualified for a grant or not approved as a transferee by the state agency, or (2) ceases to be a public or other nonprofit hospital, outpatient facility, facility for long-term care or rehabilitation facility, then the government may recover grant funds used for the construction or modernization.¹⁶ Accordingly, a bankruptcy sale of a nonprofit hospital's assets to a for-profit hospital system or investor may result in the government's ability to recover these funds, regardless of whether the government participates in the bankruptcy case.¹⁷ The BAPCPA amendments would limit a nonprofit hospital debtor's ability to transfer its assets free of this liability.

A hospital subject to state licensure rules typically will hold a number of permits, which often require a notice and approval process for transfer. Nonprofit and public hospitals will likely be bound by many of these restrictions, including requirements for (1) state license transfer, (2) change of ownership for Medicare provider agreements, (3) notification to the Joint Commission on Accreditation of Health Care Organizations, (4) transfer of DEA registration, (5) transfer of pharmacy permits, (6) necessary local and federal environmental compliance, (7) compliance with regulations regarding radioactive materials and radiation machines, and (8) compliance with any certificate-of-need laws, to the extent applicable.

Antitrust Considerations

With the trend of consolidation in the hospital industry, it is important to note that the Bankruptcy Code does not give a debtor the ability to consummate a transaction that would violate federal (and, under §363(d) or 541(f), state) antitrust statutes. The principal federal antitrust statutes affecting the acquisition of hospitals are the Sherman Act and the

¹⁰ 11 U.S.C. §363(d)(1).

¹¹ H.R. Rep. No. 109-31, pt. 1, at 145 (2005).

¹² 11 U.S.C. §1129(a)(16).

¹³ H.R. Rep. No. 109-31, pt. 1, at 145 (2005).

¹⁴ 11 U.S.C. §541(f).

¹⁵ See, generally, title VI and title XVI of the Public Health Services Act. 42 U.S.C. §§201, et seq.

¹⁶ 42 U.S.C. §2911(a); *U.S. v. St. John's General Hosp.*, 875 F.2d 1064 (3d Cir. 1989).

¹⁷ *U.S. v. Brady*, 385 F.Supp. 1347 (S.D. Fla. 1974).

Clayton Act. Section 1 of the Sherman Act generally prohibits contracts, combinations and conspiracies that unreasonably restrain trade,¹⁸ and Section 2 generally restricts monopolization, attempts to monopolize and conspiracies to monopolize.¹⁹ Section 7 of the Clayton Act prohibits mergers, joint ventures, and consolidations or acquisitions of stock or assets that substantially lessen competition or tend to create a monopoly.²⁰ In addition, the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, was adopted to provide the federal government with the opportunity to review the potential effects on competition of certain mergers, acquisitions or other consolidations. In addition to federal regulation, most states have antitrust statutes. Neither the Bankruptcy Code nor other applicable laws explicitly exclude or exempt combinations in the bankruptcy context (although an accelerated timeframe for precombination notifications is contemplated). Since a bankruptcy sale does not provide a means around these restrictions, if the potential sale would result in a combination of hospitals with a large market share, antitrust work should begin immediately.

Hospital Real Property Leases and Landlord Rights

In the event that a hospital does not own its real property, the underlying lease and terms common in hospital leases may raise additional issues that would not arise in the typical corporate chapter 11. For example, many hospitals are owned by real estate investment trusts that acquired the facilities in sale/leaseback transactions. As a means of protecting the landlord's investment and minimizing the likelihood of leaving the landlord with an empty and useless building, it is not uncommon for the hospital lease to contain provisions designed to empower the landlord to operate the hospital at the expiration of the lease term. Some leases may require the tenant to operate the leased premises continuously as a hospital of a designated type through the end of the lease term. The hospital lease may give a landlord an option to acquire all of the tenant hospital's personal property (e.g., furniture, fixtures, equipment, contract rights and even its name) at either market value or less depending on whether the tenant is in default. This option may also require the tenant to

use its best efforts to assign all contracts related to the operation of the hospital to the landlord, including its licenses and certificate of need. These types of lease provisions clearly contemplate the landlord stepping into the tenant's shoes and operating the facility to protect the landlord's investment. Similar provisions are often found in other leases of single-purpose facilities.

It is not clear whether these hospital lease options and limitations will be enforceable in the bankruptcy context. These types of provisions in the general corporate context often are ignored or modified. The enforcement of these restrictions or option may impact the value that is recoverable by the debtor hospital or its ability to pursue a traditional sale process. Maximizing value is not the be-all and end-all in these situations. A hospital debtor and landlord should be aware of these provisions and attempt to clarify their enforcement. For example, the landlord may want to consider filing a motion for orders providing adequate protection and, alternatively, injunctive relief under §363(e) of the Bankruptcy Code and/or declaratory relief to obtain some or all of the relief that would be needed to provide the landlord with necessary access and cooperation prior to its takeover of the operating hospital.

Automatic Stay and Special Problems Regarding Medicare Recoupment and Setoff²¹

Hospitals receive Medicare or similar payments from government agencies as reimbursement for services provided. These payments are sometimes made before the agency has determined whether the hospital is fully entitled to reimbursement. The hospital is legally obligated to return any overpayments. However, if the hospital files for bankruptcy before remitting overpayments, the automatic stay may or may not, depending on the nature of the hospital's obligations, prevent actions by the agency to recover the funds, either directly or by way of recouping the obligation from future amounts due to the institution.

Whether and under what circumstances the federal government can collect Medicare overpayments made to a hospital when that hospital files for bankruptcy continues to be an unsettled

question in the courts. In many cases, the answer to that question will hinge on the precise terms of the obligation and whether the debtor assumes or rejects the operative agreement. Whether the government has a right of setoff or a right of recoupment under applicable nonbankruptcy law may also be a factor.

The payor's ability to recover overpayments may also depend on the bankruptcy court's characterization of the provider agreement. If the agreement is deemed to be a series of separate contracts, the payor's recovery action will be deemed an impermissible setoff. This is the minority view. The majority of courts find that a provider agreement is a single-integrated transaction, such that the payor's recoupment of overpayments does not violate the automatic stay. Recognizing the potential limited applicability of one of the most desired and powerful bankruptcy protections is of the utmost importance and impacts the projected cash flow of a hospital debtor in any bankruptcy filing.

Moreover, the general likelihood that any provider number or provider agreement will be assumed in the bankruptcy means that a hospital buyer is not better off buying the assets in a bankruptcy than outside of bankruptcy. The majority view seems to be that the provider number/provider agreement is an executory contract that must be assumed or rejected and not an asset sold under §365. Rejection of the provider number/provider agreement would require the buyer to obtain a new number (or rely on its own number, if it has one). In the event that the provider number/provider agreement is assumed, a buyer would be subject to all the preassignment liabilities for overpayments, recoupment, fees and anything else arising under the provided number or agreement. In addition to the cash-flow issues discussed, there may not be a good way for a hospital or its buyer to shed the attendant liabilities.

Conclusion

An ailing hospital should recognize that miraculous §363 sale cures and benefits touted by corporate chapter 11 debtors often will still require hospital debtors to satisfy the myriad of requirements and restrictions present outside of bankruptcy. Accordingly, distressed hospitals may be better off pursuing alternative restructuring methods before they commit to the title 11 treatment. ■

¹⁸ 15 U.S.C. §1.

¹⁹ 15 U.S.C. §2.

²⁰ 15 U.S.C. §18.

²¹ See Louis E. Robichaux IV, Holland O'Neil, Nanette Beaird and Russell Perry, "On Life Support? Selling Health Care Assets in Chapter 11," *ABI Journal*, Vol. XXVIII, No. 7, September 2009.