Consumer Bankruptcy/Health Care

Who Pays the Price for Health Care Insolvencies: the Consumer, the Vendors or the Public at Large?

Louis E. Robichaux, IV
Deloitte Transactions & Business Analytics LLP; Dallas

Hon. Thomas A. Waldrep, Jr. (ret.)
Womble Carlyle Sandridge & Rice, LLP; Winston-Salem, N.C.

Scott A. Zuber
Chiesa Shahinian & Giantomasi PC; West Orange, N.J.

Clifford A. Zucker
CohnReznick Advisory Group LLP; Edison, N.J.

Consumer Bankruptcy/Health Care

Who Pays the Price for Health Care Insolvencies: the Consumer, the Vendors or the Public at Large?

Louis E. Robichaux, IV
Deloitte Transactions & Business Analytics LLP; Dallas, TX

Thomas A. Waldrep, Jr.
Womble Carlyle Sandridge & Rice, LLP; Winston-Salem, NC

Scott A. Zuber
Chiesa Shahinian & Giantomasi PC; West Orange, NJ

Clifford A. Zucker
CohnReznick LLP; Edison, NJ

SELECT TRENDS IMPACTING HEALTH CARE PROVIDERS

Health Care Providers Continue to Pursue Strategic M&A Activity[1]

Independent hospitals and clinicians are finding it difficult to compete with integrated systems and public companies up and down the value chain. Providers and insurers are grappling with reimbursement changes that are putting an emphasis on quality and value over volume. The pressure on referral networks, negotiating leverage and group purchasing power places the independent providers at a considerable competitive disadvantage. Recent and ongoing M&A activity has allowed successful providers to: (i) take advantage of historically low cost of capital; (ii) expand the continuum of care; (iii) achieve vertical and horizontal diversification through ambulatory expansion; and, (iv) incorporate post-acute care networks.

Many industry observers have noted that health care providers seem to be deemphasizing traditional M&A activity in favor of creative affiliations, joint ventures and partnerships. Even the most healthy systems appear to be pursuing joint ventures, open collaboration platforms and non-traditional partnerships to remain competitive.

[1] Modern Healthcare "*Dealmaking Keeps Up Heady Pace*", January 23, 2016

Key National Trends Driving Hospital Partnership / Affiliation

Key Trend	**Implications for Hospitals**
Continued Implementation of the Affordable Care Act ("**ACA**")	• Shift from fee-for-service to value-based payments • Population health management / risk readiness • Hospital-centered to hospital-avoidance • Hospital / physician alignment across continuum of care • Transparency and direct linkages between payments and quality
Increasing Need for Capital Investment	• Information Technology and Decision Support • Modernization of diagnostics and facilities • New / evolving outpatient care outlets
Payor Consolidation	• Maintaining "balance of power" • Need for reasonable / sustainable payment rates
Evolving Consumerism	• Serving aging, information savvy, and consumer-driven patient populations

ACA Success Summary[2]

One of the goals of the ACA was to increase the pool of payors into the Country's healthcare system to address near-term cost inflation and the longer term demographic problems of a greying population (Medicare participants 55 million now, growing to 75 million in 2026) that is threatening the solvency of the Medicare program, if not the entire Country, if allowed to go unchecked. In some ways, the ACA has been successful – notably, uninsured individuals have dropped from 18% of the population to less than 12% as of 1Q2015. Households now pay for 11.5% of all personal healthcare costs, down from 11.9% in 2013 and 13.1% in 2008.

[2] Modern Healthcare "*What's Behind the Out of Pocket Cost Problem*", January 9, 2016

ACA Risks[3]

However the overall provider-payor system is stressed. In 2015, for the first time in history the U.S. Federal government spent more on healthcare than on Social Security. Twelve of the original 23 healthcare exchanges have failed after a steep cut in risk-corridor payments. In 2015 and 2016, UnitedHealth expects to lose approximately $1 billion on exchange plans and may leave the exchange market altogether in 2017 as it has concluded that exchange patient populations are sicker than the overall population. Over 88% of enrollees are in high-deductible plans where they struggle to pay their deductible. Twenty-six percent of Americans under age 65 reported they had problems paying their medical bills in 2015. Cost savings initiatives have proven to be difficult.

High Deductible Plans[4]

Over 88% of people that obtained insurance from one of the ACA exchanges are enrolled in either a bronze (20.4%) or silver (68.2%) plan. A Modern Healthcare analysis of 2014 and 2015 data found that the average premiums for a 40-year-old went down year-over-year in most

[3] Modern Healthcare "*What's Behind the Out of Pocket Cost Problem*", January 9, 2016
[4] Source: Modern Healthcare Data Analysis, October 30, 2015

exchange plans, but average deductibles went up from 2014 to 2015 and averaged more than $2,800 for a 40-year-old with a silver plan and more than $5,100 for a bronze plan. Data for 2016 suggests that high-deductible options again will be the most common offering. The benchmark plans, or the second-lowest-cost silver plans that determine a person's premium subsidy, will rise by 7.5% on average in 2016. The bronze and silver plans were selected by many individuals based on the low monthly premiums; however, these plans also included high deductibles. Many people discovered this tradeoff only when they used their insurance for the first time as an insured patient.

A new study from the Bureau of Economic research concluded that with high out-of-pocket cost plans, the sickest workers were most likely to skip medical care, including preventative care which reduces longer term overall costs. The average deductible — the amount employees have to pay out-of-pocket before the first dollar of insurance kicks in — increased 8.3% to $1,318 for single coverage in 2015. Overall, about 24% of workers in employer plans were enrolled in a high-deductible plan with some type of savings account in 2015, compared with 20% in 2014. In 2006, only 4% of employees were in high-deductible plans.[5] High-deductible plans are a growing problem for providers, too. These plans can cause financial problems when providers cannot collect from individuals who don't have enough income to cover their deductibles and co-pays.

Cost Containment – Providers & Insurers

The focus for both providers and insurers has been to move more services to lower cost settings. The "hub & spoke" systems which were previously used to funnel patients from community hospitals to flagships centers are now being reprogrammed to send patients well

[5] Kaiser Family Foundation and the Health Research & Educational Trust, September 22, 2015

enough to travel from flagships back to lower cost community hospitals. This trend often involves the expansion of services to community health centers and outpatient facilities. Provider consolidation will allow for the reduction of duplicative overhead costs, and economies of scale in expensive IT systems. Investment in IT and analytical capabilities are helping health systems understand the true costs of care (cost accounting / activity trackers). Obtaining a clear understanding of costs is the first step in allowing hospitals to operate more efficiently and eliminate waste and unnecessary activity. Additionally, insurers and providers are maintaining pressure on the pharmaceutical industry to keep drug prices under control, with limited success. Spending on drugs rose by 11.6% in 2014 (Source, the Kaiser Family Foundation). Generic drug prices increased 9% in 2014.

Technology – The Future of Health Care Delivery[6]

The future of health delivery technology is in the palms of the consumers' hands. Smartphone applications such as otoscopes, activity trackers, scales, health apps allow for up to the minute information to be recorded and reviewed by clinicians. Half of all Americans now own a smartphone. The challenge is to translate this opportunity to benefit individual physicians. Modern Healthcare recently quoted a physician on this challenge "*[A]s a physician, I am inundated by sales pitches and e-mails that offer another app to use or portal for me to check, adding work with no return on investment for me as a physician. The products that really understand our workflow will rise to the top.*" Opportunity exists for more telehealth, e-visits and additional remote monitoring, but raises the issues of Health information security and large required capex investment in systems and security personnel. With the consolidation of many

[6] Modern Healthcare "*Many Digital Health Products Fail to Offer Sufficient ROI*", January 23, 2016

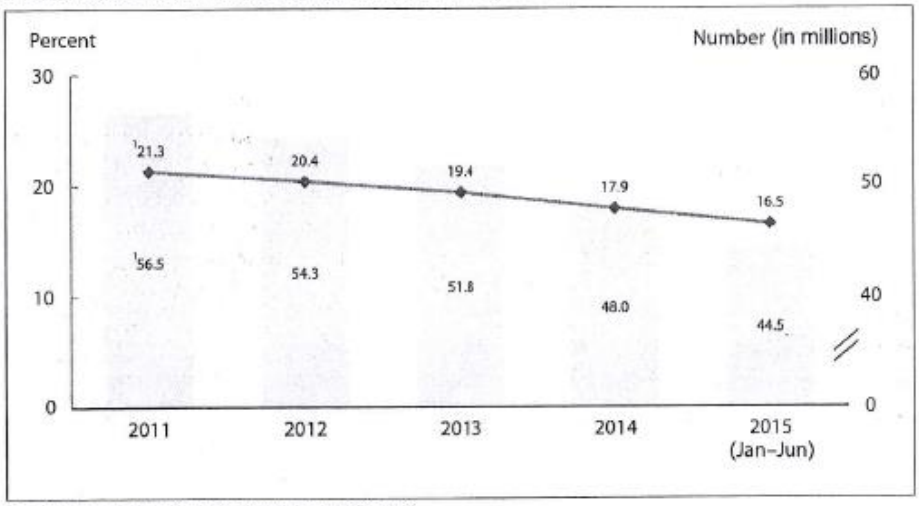
providers, there is the opportunity to translate the "Big Data" into insights of a population that can be of practical use at the patient level.

Consumers

Trend of Medical Debt[7]

From early 2011 until early 2014 approximately 20% of people under the age of 65 were in a family that had problems paying medical bills within a year. Thankfully these numbers continued to decline throughout 2014 and into 2015, showing more than a 20% drop from the 2011 levels. In 2015 the estimate of people in a family having problems paying medical bills dropped to 44.5 million from 56.5 million in 2011.

Figure 1. Percentage and number of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by year: United States, 2011–June 2015



[1]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

The Effect of Medical Debt[8]

[7] National Center for Health Statistics *"Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates From the National Health Interview Survey, 2011-June 2015"* December 2015

Even though medical debt has been declining the last couple of years it is still a significant burden to many and a major problem in this country. The Kaiser Family Foundation/New York Times Survey that was taken in the third quarter of 2015, showed the effect on families for those who had problems paying medical bills in the past 12 months and what they action they had to take to pay those medical bills.

	Among those who had problems paying medical bills in past 12 months		
Percent who say they or someone else in their household has done each of the following in the past 12 months in order to pay medical bills:	Total	Insured	Uninsured
Put off vacations or other major household purchases	72%	77%	64%
Cut back spending on food, clothing, or basic household items	70	75	62
Used up all or most of savings	59	63	51
Taken an extra job or worked more hours	41	42	40
Borrowed money from friends or family	37	37	38
Increased credit card debt	34	38	24
Taken money out of retirement, college, or other long-term savings accounts	26	31	17
Changed your living situation	17	14	23
Taken out another type of loan	15	17	11
Borrowed money from a payday lender	13	15	12
Sought the aid of a charity or non-profit organization	12	11	15
Taken out another mortgage on home	2	1	2
Made other significant changes to way of life	15	15	16

The catastrophic effect these bills have on many families is irrelevant to whether or not they have insurance. In this survey over 60% of those reporting medical debt had insurance. The problem stems from those with insurance having higher deductible plans, repeated co-pays or from out-of-network coinsurance all of which add significant cost sharing. The long term effect of medical bills piling up can be a cause of additional mental and physical stress on the families.

[8] Kaiser Family Foundation/New York Times Medical Bills Survey *"The Burden of Medical Debt"* January 2016

Many people with medical bill problems report being contacted by collection agencies. Of those contacted twice as many are being contacted due to medical bills versus some other type of bill. For some the next step is bankruptcy.

	Among those who had problems paying medical bills in past 12 months		
Have you ever declared personal bankruptcy, or not? Did you declare bankruptcy mainly because of medical bills, mainly because of some other type of debt, or both?	Total	Insured	Uninsured
Declared bankruptcy in the past 12 months	2%	3%	1%
Declared bankruptcy more than 12 months ago	16	18	12
Total declared bankruptcy (NET)	**18**	**21**	**14**
Because of medical bills	3	3	3
Because of some other type of bills	7	9	4
Because of both	8	10	7
Never declared bankruptcy	82	79	86

NOTE: Don't know/Refused responses not shown.

Bankruptcies Caused by Medical Debt

According to a 2014 study, between 18 and 25% of all U.S. bankruptcies were caused by medical debt. The average amount of medical debt in consumer filings was $8,594. Stephanie Frances Ward, *Will the Affordable Care Act lead to fewer personal bankruptcy filings?*, (July 1, 2015) http://www.abajournal.com/news/article/will_the_affordable_care_act_lead_to_fewer_personal_bankruptcy_filings/. However, there has been speculation that the Affordable Care Act may lead to fewer medical-related filings because it aids low income people in purchasing health insurance. Id.

Treatment of Medical Debt in Bankruptcy

Medical debt is treated as nonpriority unsecured debt in Chapter 7 bankruptcy. See 11 U.S.C. § 507 (detailing the bankruptcy priority scheme). Depending on the debtor's assets, a portion of the debt may be paid through the bankruptcy, and the remainder will be discharged

when the debtor receives his discharge in the case. See 11 U.S.C. § 727(b)(describing the Chapter 7 discharge).

In order for an individual debtor to be eligible for Chapter 7 relief, the debtor must pass the "means test." 11 U.S.C. § 707(b)(1). Under the means test, a debtor with above-median income must show that after considering his reasonable expenses, he does not have excessive disposable income. See 11 U.S.C. §707(b)(2)(A). If a debtor fails the means test, his case may be dismissed or converted to a Chapter 13 or Chapter 11 case. 11 U.S.C. § 707(b)(1).

There is an exception to the means test such that a debtor whose debts are primarily "non-consumer" will not have to pass the means test. 11 U.S.C. § 707(b)(2); see also 11 U.S.C. § 101(A)(8) (defining "consumer debt" as "debt incurred by an individual primarily for personal, family, or household purposes."). There is a dearth of case law on the issue of whether medical debt is considered to be "consumer" debt, and courts have gone both ways on this issue. Compare In re Morse, 164 B.R. 651, 653 (Bankr. E.D. Wash. 1994) (identifying medical debt as consumer debt); with In re Dickerson, 193 B.R. 67 (Bankr. M.D. Fla. 1996)(listing medical bills as non-consumer debts). If the medical debt is considered to be "consumer," and it accounts for a large portion of the debtor's debts, it will be more likely that the debtor will not be eligible for the § 707(b)(2) exception. However, even if the debtor fails the means test, if the debtor has a "serious medical condition," the debtor may rebut the presumption of abuse that arises as a result of failing the means test. 11 U.S.C. §707(b)(2)(B)(i). If the debtor can rebut that presumption, he will still be eligible for Chapter 7 relief. The Bankruptcy Code and the case law provide little to no guidance on what constitutes a "serious medical condition."

If a debtor is not eligible for Chapter 7, he may still seek bankruptcy relief in Chapter 13. Medical debt is also dischargeable in Chapter 13; however, more of the debt may ultimately be

repaid in a Chapter 13 case, as the debtor will be required to contribute his disposable income towards a three to five-year payment plan, before receiving a discharge of his debts. See 11 U.S.C. § 1328 (regarding discharge in Chapter 13) and 11 U.S.C. § 1322 (regarding the Chapter 13 plan requirements).

Other Issues Arising in Medical Bankruptcies

I. Doctrine of Necessities

Depending on the applicable state law, the doctrine of necessities may affect whether both spouses are liable for one of the spouse's medical debts. This can be significant where marital property is owned by the spouses as tenants by the entireties. Typically, only a joint creditor can execute on property owned by the spouses as tenants by the entireties. However, if under the doctrine of necessities, one spouse's medical debt becomes the liability of the other spouse, the creditor may then be able to execute on and seek payment from the entireties property. See, e.g., Moses H. Cone Mem'l Hosp. Operating Corp. v. Hawley, 195 N.C. App. 455 (2009).

II. HIPAA Violations

The Health Insurance Portability and Accountability Act (HIPAA) sets standards in connection with the use and disclosure of an individual's health information. Among other things, HIPPA prevents the disclosure of a patient's personally identifiable information. 45 C.F.R. § 164.520. Creditors such as hospitals and medical practices should therefore take care to prevent inappropriate disclosure and to comply with the requirements of HIPAA. However, courts have held that there is no private cause of action for a HIPAA violation. E.g., In re Dunbar, 446 B.R. 306, 309 (Bankr. E.D. Ark. 2011); In re Maple, 434 B.R. 363, 371 (Bankr. E.D. Va. 2010). A private right of action may exist, though, under applicable state law

pertaining to the disclosure of private medical information. See, e.g., In re Mallard, No. 12-52552, 2014 WL 988779, at *6 (Bankr. E.D. Ky. Mar. 12, 2014) (private right of action existed under Kentucky law to sue for disclosure of HIV test results).

III. Resident Deposits in Continuing Care Retirement Communities

Residency in a Continuing Care Retirement Community ("CCRC") often requires a substantial upfront deposit by the resident, which the resident gives as consideration for lifetime care from the CCRC. If the CCRC were to subsequently file for bankruptcy protection, it may seek to reject its executory contracts under 11 U.S.C. § 365(a), including its lifetime care contracts with residents. The resident would then have a claim for rejection damages against the debtor/CCRC; however, the payout, under the Bankruptcy Code's priority scheme may result in a return to the resident of pennies on the dollar. Nancy A. Peterman, et. al, *Protecting Residents of Continuing Care Retirement Communities*, ABI Journal, Vol. XXII, No. 2, March 2003; see 11 U.S.C. § 507 (detailing the Bankruptcy Code's priority scheme).

Vendors - Introduction

Vendors in healthcare insolvencies are negatively affected in a number of ways. A bankruptcy filing by a vendor's customer will invariably lead to decreased revenue and profitability for the vendor, which, depending upon the magnitude of such lost revenue and the size of the vendor, could cause the vendor to file its own bankruptcy petition or, at a minimum, be forced to reduce its workforce. Margins for vendors in the healthcare arena are typically very small, so even modest reductions in revenue can have a big impact upon the vendor's operations and its balance sheet. Further, in addition to suffering lost revenue as a result of not being paid its pre-petition claims, vendors often will lose future revenue as a result of not having a business

relationship with the purchaser of a healthcare debtor. Asset sales in healthcare insolvencies can lead to less providers and higher prices for vendors and, ultimately, for consumers.

Be Proactive

In order to maximize recoveries and minimize losses and the negative consequences associated with a customer's bankruptcy filing, vendors need to be proactive both before and during bankruptcy cases. Pre-petition, vendors must be acutely aware of, among other things, the nature of their customer's business operations, its income and revenue drivers, and its customer's relationships with its customers and lenders. Vendors must be cognizant of "warning signs" that their customers may be having financial difficulties. Such warning signs include: (i) changes in accounts receivable performance - a clear warning sign is when receivables turn over slower than usual and aging becomes more dated. A related sign is when A/R turnover is slowing down, but there is no commensurate increase in aging spread; (ii) changes in the vendor's customers' customer base - vendors must be diligent in reviewing their customers' most important customers on a regular basis. If the vendor's customers' top customers are not stable, that could be sign of trouble; (iii) where a customer's credit lines are maxed out or close to being at their limits with their lenders; (iv) overdrafts and bounced checks; (v) accounts payable being stretched - if the vendor's customers are not raising cash through means other than stretching the trade (such as selling inventory or raising equity), then it must stretch trade debt, which will show up in the condition of the payables; and (vi) where a secured vendor's collateral review does not reconcile - if the vendor is secured, it must pay close attention to its collateral base/position.

In addition, vendors must be diligent in reviewing cash collateral and DIP financing motions and orders, including accompanying budgets, to make sure that their rights are not being compromised and that there is money available for the debtor to pay for goods post-petition.

Minimize Risks

Vendors can do certain things to minimize these risks, including: (a) being very familiar with its documents; it must know its rights and remedies; (b) monitoring credits diligently; a vendor should not make too many concessions and, if it does, it should seek enhanced protections. Any accommodations must be accompanied by a full reservation of rights, so that the accommodations are not later deemed to be contract term modifications; (c) pushing hard for payments – don't focus too much on whether payments may be subject to disgorgement as a preference. Preference actions can be defended – vendors rarely pay anything near 100%; (d) exercising rights and remedies - change terms as allowed by the contract or in accordance with the Uniform Commercial Code (discussed below); (e) asking for additional assurance of performance, such as security deposits, guaranties or additional collateral; (f) checking with counsel regarding technical requirements, such as notices required under PACA or PASA, to protect rights in the face of "secret" or "inchoate" liens; (g) being familiar with the law, so that the vendor does not run afoul of, among other things, the automatic stay; and (h) seek to become a critical vendor, assuming the vendor does not have a contract (which, typically, will prevent the vendor from being deemed a critical vendor, as the vendor will be required to perform under the contract, unless it obtains stay relief to terminate same).

Rights under the Uniform Commercial Code (the "UCC")

Under the UCC, vendors have certain rights with which they must be familiar. If the vendor determines that its buyer is insolvent, the vendor may refuse delivery except for cash,

including payment for all goods previously delivered under the contract, and may stop delivery. UCC Section 2-702. This applies even where there is a governing contract that includes credit terms and even if the contract does not allow for a change in terms. Further under Section 702, where the seller discovers that the buyer has received goods on credit while insolvent he may reclaim the goods upon demand made within ten days after the receipt (but if misrepresentation of solvency has been made to the particular seller in writing within three months before delivery the ten day limitation does not apply). However, the seller's right to reclaim is expressly subject to the rights of a buyer in the ordinary course (which includes a prior, blanket lienholder) or other good faith purchaser. Moreover, successful reclamation of goods excludes all other remedies with respect to them.

If the vendor has a contract with the Debtor, considerations are a little different. First, the vendor cannot change contract terms post-petition without violating the automatic stay. Second, if the vendor has a contract, it will ordinarily not be eligible for critical vendor status and must move for stay relief to terminate the contract.

A seller of goods may also stop delivery of goods in the possession of a carrier or other bailee when he discovers the buyer to be insolvent (Section 2-702) and may stop delivery of carload, truckload, planeload or larger shipments of express or freight when the buyer repudiates or fails to make payment due before delivery or if for any other reason the seller has a right to withhold or reclaim the goods.

In short, U.C.C. Section 2-702 provides the seller with three rights, depending upon the location of the goods at the time the seller discovers the buyer's financial condition. The seller may: (1) reclaim goods already in the actual or constructive possession of the buyer, (2) stop deliveries of goods already in transit (regardless of who holds title to the goods), and/or (3) refuse delivery of

pending or future orders (regardless of who holds title to the goods). However, reclamation rights may not be particularly valuable to the vendor, as where the goods are no longer in the buyer's possession or have been pledged as collateral to a blanket lien secured creditor.

Rights under the Bankruptcy Code

Once a bankruptcy petition has been filed, a seller's reclamation rights are governed by Section 546(c) of the Code. Section 546(c)(1) provides, as follows:

> (c)(1) Except as provided in subsection (d) of this section and in section 507(c), and subject to the prior rights of a holder of a security interest in such goods or the proceeds thereof, the rights and powers of the trustee under sections 544(a), 545, 547, and 549 are subject to the right of a seller of goods that has sold goods to the debtor, in the ordinary course of such seller's business, to reclaim such goods if the debtor has received such goods while insolvent, within 45 days before the date of the commencement of a case under this title, but such a seller may not reclaim such goods unless such seller demands in writing reclamation of such goods –
>
> (A) not later than 45 days after the date of receipt of such goods by the debtor; or
>
> (B) not later than 20 days after the date of commencement of the case, if the 45-day period expires after the commencement of the case.

In short, to assert successfully a reclamation claim under Section 546(c): (a) the goods must be sold in the ordinary course of seller's business; (b) the debtor must have been insolvent at the time the goods were received; (c) the debtor must have received the goods within the forty-five (45) days before the petition was filed; (d) the seller must make a timely written reclamation demand; and (e) the good must be in the buyer's possession and identifiable. And, as noted in

the statute itself, a seller's reclamation rights are subject to the rights of a holder of a security interest in the goods or the proceeds thereof (which is virtually every case).

Section 546(c)(2) provides:

> (2) If a seller of goods fails to provide notice in the manner described in paragraph (1), the seller still may assert the rights contained in section 503(b)(9).

11 U.S.C. Section 503(b)(9), in turn, provides, in relevant part, as follows:

> (b) After notice and a hearing, there shall be allowed administrative expenses…
>
> (9) the value of any goods received by the debtor within 20 days before the date of commencement of a case under this title in which the goods have been sold to the debtor in the ordinary course of such debtor's business.

In order to assert a Section 503(b)(9) claim, the vendor/creditor must file a motion for allowance and/or payment, under Code Section 503(b), (a). The exception is where there has been a procedures order entered by the court, typically upon request of the debtor, which provides for assertion of Section 503(b)(9) claims by way of a proof of claim. A vendor should assert its Section 503(b)(9) as early as possible. One issue always facing vendors is whether to seek allowance, but not immediate payment, of its 503(b)(9) claim. Most often, our vendor clients will move for both allowance and payment, but will typically back off on the request for immediate payment, as the Court's generally will not direct immediate payment, except where the debtor has a lot of available cash and it is relatively clear that the case is, and will likely remain, administratively solvent.

Conclusion

In sum, vendors can be impacted by, and "pay the price" for, healthcare insolvencies. In order to minimize the negative impact of such bankruptcies, vendors must be proactive and fully familiar with the law, both the Bankruptcy Code and applicable state law, including the UCC.