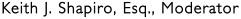
# American Bankruptcy Institute Caribbean Insolvency Symposium

November 11-12, 2004

# Latest Developments in Health Care Bankruptcies



Co-Chair, National Reorganization, Bankruptcy & Restructuring Practice Co-Managing Shareholder Greenberg Traurig, LLP, Chicago shapirok@gtlaw.com 312.456.8400

#### William W. Kannel, Esq.

Member Mintz, Levin, Cohn, Ferris, Glovsky & Popeo P.C., Boston, Massachusetts bkannel@mintz.com 617.542.6000

### Harold L.. Kaplan, Esq.

Chairman
Gardner Carton & Douglas LLP, Chicago hkaplan@gcd.com
312.569.1000

#### Deirdre M. Richards, Esq.

Attorney The Bayard Firm, Wilmington, Delaware drichards@bayardfirm.com 302.655.5000

#### Clifford J. White, Esq.

Deputy Director for Executive Office of Unites States Trustees U.S. Department of Justice, Washington, D.C. 202.307.1391

## ABI Caribbean Insolvency Symposium Panel on Healthcare Bankruptcies November 12, 2004

#### I. INTRODUCTION

- A. There have been numerous bankruptcies in the healthcare industry during the past ten years, involving all sectors of the industry, including:
  - Home health agencies
  - Therapy companies
  - Physician practice management companies
  - Nursing homes
  - Assisted living facilities
  - Hospitals
- B. Some Causes of Recent Bankruptcies in the Healthcare Industry:
  - 1. Acquisitions without adequate integration
    - Some companies expanded too quickly, assuming "bigger was better" and acquiring new branch facilities without being prepared to integrate them into existing operations.
  - 2. Too many beds in hospitals and nursing homes
  - 3. Changes in Medicare laws—Prospective Payment System (PPS)
    - Resulted in significant reduction in cash flow for healthcare companies
    - The PPS was implemented over time, hitting different sectors of the industry at different times.
    - Companies have not been timely or fully reimbursed by the government for costs. Under the PPS, for several years, the amounts of reimbursements were reduced. More recently, the government has made over-payments, which it has later sought to recoup from subsequent amounts owed to healthcare providers, often when they are already in financial distress.
  - 4. Over-leveraged bond financing by not-for-profit healthcare organizations

#### II. ISSUES ARISING IN BANKRUPTCIES OF HEALTHCARE COMPANIES

#### A. Commencement of the Case

- 1. Voluntary vs. Involuntary
  - Distinction presents issues unique to heathcare industry

#### 2. Involuntary Bankruptcy Petitions

- a. In preparing to exercise this option, creditors have tremendous prebankruptcy negotiating leverage with a healthcare debtor
- b. Involuntary relief not available to creditors of a non-profit healthcare organization (no involuntary petitions; no involuntary conversion from Chapter 11 to Chapter 7)

#### B. Eligibility to be a Debtor

- 1. Who can and cannot file
- 2. For example, insurance companies (including HMOs) are liquidated pursuant to state law, and not under the Bankruptcy Code.

#### C. Employee Issues

- 1. Priority claims for pre- and post-petition salaries.
- 2. A key employee incentive program ("KERP") may be necessary to prevent employee departures from a healthcare debtor.
- 3. For a healthcare organization in Chapter 11, a KERP may be necessary not only for essential officers in the debtor's management, but also for other healthcare professionals who cannot be replaced easily. For example, there is a shortage of nurses throughout the healthcare industry, which may add to the need for a KERP for these professionals.

#### D. Critical Vendor Payments

- Identifying creditors critical to the debtor's business and seeking permission to pay their claims if payment is necessary to continue business
- Practice was routine but has come under recent criticism
- The practice is no longer allowed in the Seventh Circuit under courts' general equitable powers (11 U.S.C. §105(a)). Under the recent <u>Kmart</u> opinion, it may still be allowed under Section 363 of the Bankruptcy Code, but on a limited basis.

• For a healthcare organization even under current scrutiny of critical vendor payments, it may be easier to obtain this status for suppliers of blood, oxygen, pharmaceuticals and other products necessary to sustain life. Still, a court may require proof that such supplies are not available from competitors of suppliers listed on a debtor's "critical vendor list."

#### E. Cash Flow Issues

- 1. Will Medicare or Medicaid stop paying?
- 2. Potential for bankruptcy court injunction to force payment.
- 3. Setoff / Recoupment Issues
  - Government has used recoupment theory to offset past overpayments against postpetition receivables.
  - Automatic stay would normally require government to seek recovery of overpayments through claim process, and continue paying postpetition reimbursements.
  - However, if competing claims arise from the same transaction, recoupment may be possible. The issue turns on whether the two obligations arise under a single contract or transaction.
  - If the government can recoup, this can present a significant cash flow problem for a healthcare provider in Chapter 11.

#### F. Executory Contract Issues

- 1. Assumption of Medicare and Medicaid contracts
- 2. If a master lease and property-specific leases govern multiple properties (e.g. for nursing homes), a debtor-tenant is limited in its discretion to reject unfavorable leases and assume favorable ones
- 3. Majority rule is that a provider agreement is an executory contract
- 4. How can nursing home operators minimize their liability to landlords? Typically, a company operating a group of nursing homes leases all of the facilities from one or more lessors. Under the leases, the lessors often acquire a security interest in the operators' receivables and other assets, to guaranty payment on the leases. This can become an enormous liability leaving an operator with little-to-no flexibility when it goes into financial distress. What can operators do to avoid this situation before entering the zone of insolvency? What options do operators have in the zone of insolvency?

#### G. Plan Issues

- 1. Absolute priority rule may work differently for not-for-profit debtors.
- 2. Nearly all healthcare bankruptcies result in a sale or series of sales of substantially all of the debtor's assets. This can be done through a liquidating plan.
- 3. Exit financing difficult because there are relatively few lenders in the healthcare industry.
- H. Sales and Closure of Healthcare Organizations
  - Both present federal and state regulatory issues
- I. Developing Case Law on Fiduciary Duties
  - 1. During the past decade, a body of case law has developed holding that officers and directors of a corporation in the "zone of insolvency" owe fiduciary duties to creditors.
  - 2. How these duties co-exist with or supersede duties to shareholders is the subject of continued development in case law, in which courts have reached different holdings.
  - 3. For financially distressed healthcare companies (particularly if they are non-profit companies), additional issues are presented by duties owed to persons other than creditors or shareholders (i.e. patients and the community served).
  - 4. Board members of not-for-profit debtors have particular duties.
- J. Issues Related to Medicare and Medicaid Payments
  - 1. There is still no nationwide standard on whether, and under what circumstances, the government can recoup a pre-petition claim for overpayments from post-petition reimbursements owed to a healthcare organization in bankruptcy. Case law will continue to develop on this issue.
  - 2. Medicare and Medicaid reimbursements continue to be slow to arrive. Financially distressed healthcare organizations are exploring new means of obtaining immediate financing based on expected payments from the government.
  - 3. Financial difficulties now faced by state governments may slow payments even more.

#### K. Uninsured and Underinsured Patients

- 1. The number of uninsured patients is rising, while reimbursement rates for insured patients are falling.
- 2. A "domino effect" can result when the hospital in a community closes due to inadequate reimbursements and the remaining hospitals in the community are left serving a greater number of uninsured and underinsured patients.

#### L. Issues Related to Liability Insurance

- 1. How can a health care provider in financial distress address the high cost of malpractice and other tort insurance?
- 2. Some providers self-insure, risking financial ruin and, in the case of a debtor-in-possession, huge administrative expense. What better alternatives are there?