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Health Exam: Muni Health Care Bankruptcy Under Ch. 9

Law360, New York (September 16, 2011, 1:43 PM ET) -- With the recent focus on municipal and health care bankruptcy, it is intriguing and may be particularly relevant to consider what rules apply in a Chapter 9 for a municipal health care entity such as a county or public hospital or health care taxing district.

From a statutory perspective, Chapter 9 combines (1) a few specific substantive Chapter 9 provisions (Sections 902 through 946) and (2) other Bankruptcy Code sections which are expressly incorporated into Chapter 9 proceedings through Section 901 of the Bankruptcy Code.[1]

In addition to recognizing the significant benefits (as well as certain limitations) of Chapter 9, this article will focus on the extent that the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA) provisions adopted in 2005 relating to and imposing obligations in "health care business" bankruptcies may apply in a municipal health care Chapter 9, including the recent express incorporation in Chapter 9 of the BAPCPA patient care ombudsman and patient record provisions through the December 2010 enactment of Bankruptcy Technical Corrections.

Chapter 9 Fundamentals — Eligibility, Benefits and a Few Limitations

A municipal health care entity such as a county or public hospital or health care taxing district may file for Chapter 9 protection if it qualifies as a "municipality," defined as a "political subdivision or public agency or instrumentality of a State,"[2] and, inter alia, (1) "is specifically authorized … to be a debtor under such chapter by state law, or by a governmental officer or organization empowered by state law to authorize such" (which is more the exception than the rule), (2) "is insolvent" as that term is uniquely defined in Chapter 9 and (3) "desires to effect a plan to adjust such debts."[3]

A Chapter 9-eligible municipal healthcare, (or other municipal) debtor may, similar to Chapter 11, enjoy the automatic bankruptcy stay and the ability to assume, reject or consensually adjust contracts and unexpired leases. This may include rejecting burdensome collective bargaining and other labor/retiree benefit agreements under more lenient Bankruptcy Code Section 365 (rather than pursuant to more labor-friendly Sections 1113 or 1114), which seems to be a prime recent objective for the consideration of Chapter 9, as it was in the Vallejo, Calif., case.

Unlike Chapter 11, sovereign immunity and Tenth Amendment limitations are recognized in Chapter 9, leaving even more significant control in the municipal entity, and placing special limits on the bankruptcy court's involvement. For instance, the court has no power to control or interfere with the municipal debtor's expenditures, operations or use of property during the Chapter 9.[4] This includes affording the municipal entity complete control over the retention and payment of its own and other professionals.[5] Moreover, municipal entities under Chapter 9 cannot have a plan of adjustment imposed on them, may not be subjected involuntarily to liquidation of assets, and have a good deal of discretion in proposing and securing confirmation of a plan of adjustment.[6]

The powers of a municipal debtor in Chapter 9 are not limitless, however. In particular, even in a Chapter 9, Special Revenue Bonds — which comprise a significant segment of customary municipal health care bond debt, particularly being used to finance facility projects supported by pledges of facility revenues — enjoy significant protections, largely implemented through certain amendments to Chapter 9 enacted in 1988, which should generally allow such bonds to continue to be secured, serviced and paid by the ongoing collection of pledged post-petition revenue streams.

These bondholder protections were enacted in response to the pre-1988 concern that the original express unconditional incorporation in Chapter 9 of Bankruptcy Code Sections 552, 1111(b) and 547, could be read to undercut the structural assumptions underlying revenue bonds by (1) cutting off liens on long-term Special Revenues as of the petition date, (2) turning nonrecourse into recourse debt and (3) exposing noteholders to preference attacks.

In attempting to remedy these statutory gaps the 1988 Special Revenue Bond Amendments defined "Special Revenues" in a new Section 902(23) of the Bankruptcy Code,[7] and adopted new Sections 928, 926(b) and 927 which, respectively, (1) preserved the bondholders' lien on and right to post-petition payment from ongoing pledged streams of "special revenues" notwithstanding section 552;[8] (2) insulated from preference attack under Bankruptcy Code Section 547 payments on special revenue and other bonds;"[9] and (3) provided that claims "payable solely from special revenues of the debtor under applicable nonbankruptcy law shall not be treated as having recourse against the debtor on account of such claim pursuant to section 1111(b),"[10] thereby eliminating the theoretical transformation of nonrecourse bonds into general obligation bonds.

Application in Municipal Health Care Chapter 9 of 2005 BAPCPA Health Care Business Provisions

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005,[11] for the first time adopted industry-specific bankruptcy provisions imposing patient protection and other obligations on and applicable only to "health care businesses," defined in new section 101(27A) as "any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for — (1) the diagnosis or treatment of injury, deformity or disease, and (2) surgical, drug treatment, psychiatric or obstetric care."[12]

While two BAPCPA health care provisions — amendments to section 503(b) administrative claims and section 362 stay exceptions for the U.S. Department of Health and Human Services — seem to have been from the outset incorporated into Chapter 9 through section 901 insofar as they were added to general Bankruptcy Code sections which were already (pre-2005) included in section 901, the application of two other of the most controversial and significant of the BAPCPA provisions — patient care ombudsman section 333 and patient record disposal section 351 — were debatable, at least until Bankruptcy Technical Corrections became effective on Dec. 22, 2010, and first expressly added those sections to section 901. (While each of sections 333 and 351 referenced Chapter 9, they had not previously been expressly incorporated into section 901).

On the other hand, two other major 2005 BAPCPA provisions — section 704(a)(12) requiring transfer of patients caught in the closing of a facility under Chapter 7 and section 341(f) subjecting the sale of a nonprofit facility to state regulation and nonbankruptcy law — still do not seem incorporated into Chapter 9 through section 901, although arguably as a matter of policy neither of these provisions should apply in the municipal health care reorganization context.

Thus, the following major BAPCPA health care business provisions are now incorporated into Chapter 9 through section 901 and need to be considered and applied in a municipal health care Chapter 9:

1) Section 333 Appointment of Patient Care Ombudsman

Section 333 of the Bankruptcy Code[13] — the patient care ombudsman section — is perhaps the most controversial BAPCPA health care provision, providing that, within 30 days of the commencement of any health care business bankruptcy case, the bankruptcy court should order the appointment of a disinterested patient care ombudsman "to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary … under the specific facts of the case."

The patient care ombudsman must report to the court every 60 days, either at a hearing or in writing and after notice to the parties in interest, on the quality of patient care at the debtor's facilities. If the patient care ombudsman determines that the quality of patient care provided to the debtor's patients is declining significantly or is otherwise being materially compromised, the patient care ombudsman must file a motion or written report with the court and give notice to parties in interest immediately upon making such determination.

2) Section 351 Disposal of Patient Records

The BAPCPA also added a new section 351 of the Bankruptcy Code to provide specific guidelines for the retention and disposal of patient records in bankruptcy cases. Section 351's application to a municipal health care entity under Chapter 9 was also originally left somewhat ambiguous insofar as it was not specifically incorporated in section 901 — at least not until the December 2010 Bankruptcy Technical Corrections Act. As adopted in 2005, section 351 is triggered if "the debtor or trustee does not have sufficient funds to pay for the storage of patient records in the manner required under applicable Federal or State law."[14]

It provides procedures and timetables to give notice to patients, then insurance providers (if applicable law permits the insurance provider to claim the records) and ultimately each appropriate federal agency as to their desire to take possession of the patient records.

If the patient or an insurance provider does not claim the patient records, or a federal agency does not grant the request to deposit such records with that agency, the records may be destroyed by shredding or burning if they are written or by otherwise destroying records that are magnetic, optical or in another electronic format, so that those records cannot be retrieved.

3) Section 503(b)(8) Administrative Expense Claims

The BAPCPA added section 503(b)(8) of the Bankruptcy Code (part of section 503, which was already included in section 901 and thus incorporated into Chapter 9) to grant administrative expense priority for the actual and necessary costs and expenses of closing a health care business incurred by a trustee, by a federal agency, or by a department or agency of a state or political subdivision. Such costs arguably include the costs and expenses of transferring patients (and records) from a municipal health care provider.

4) Section 362(b)(28) Automatic Stay Exception for HHS

Section 362(b)(28) as adopted in the BAPCPA (a new subsection of section 362 which was already included in section 901 and thereby incorporated into Chapter 9) clarifies that the secretary of Health and Human Services need not seek relief from the automatic stay of actions against the debtor imposed by section 362 of the Bankruptcy Code in order to suspend a bankrupt health care business from participation in the Medicare and other federal health care programs (as defined in section 1128B(f) of the Social Security Act).

Through its power to exclude a provider from the Medicare program, the act arguably gives to the HHS greater power to discourage filings and to also compel recoupment and/or set off against prepetition Medicare overpayments. Whether the HHS would or could practically use these powers against a municipal health care entity, including taking the risk of and blame for causing the possible closure of a municipal health care entity by denying it cash flow, would presumably be a case-by-case determination.

Conclusion

While questions as to the applicability, efficacy and range of Chapter 9 for municipal health care entities such as county and public hospitals and health care taxing districts may still exist, such issues have been narrowed and clarified through, among other things, the 1988 Special Revenue Bonds Amendments and certain of the 2005 BAPCPA Health Care Business Amendments in conjunction with the 2010 Bankruptcy Technical Corrections.

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[1] 11 U.S.C. §901(a).

[2] 11 U.S.C. §101(40).

[3] 11 U.S.C. §109 (c).

[4] 11 U.S.C. §904.

[5] Bankruptcy Code Sections 327-331 governing the employment and compensation of professionals and officers are not incorporated into Chapter 9 through Section 901(a).

[6] 11 U.S.C. §943(b).

[7] 11 U.S.C. §902(23).

[8] 11 U.S.C. §928.

[9] 11 U.S.C. §926(b).

[10] 11 U.S.C. §927

[11] Pub.L. 109-8, 119 Stat. 23, enacted April 20, 2005.

[12] 11.U.S.C §101(27A).

[13] 11 U.S.C. §333.

[14] 11 U.S.C. § 351.