Rural Health Care in the Age of Hospital Bankruptcies

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RURAL HEALTH CARE IN THE AGE OF HOSPITAL BANKRUPTCIES

ABSTRACT

In recent years, the United States has witnessed a surge in bankruptcy filings within the healthcare sector. Inflation, rising expenses, shifts in payment models, labor shortages, legislative uncertainty, and mounting pharmaceutical costs have impacted all healthcare organizations, casting a shadow over communities. This is particularly evident in rural America where hospital closures have shrunk access to healthcare services. This Comment delves into the challenges and interests at play when healthcare entities and nonprofit organizations navigate bankruptcy proceedings, paying particular attention to the challenges faced by health care business bankruptcy proceedings.

This Comment argues that the current bankruptcy framework requires adjustments to meet the pressing needs of contemporary nonprofit health care businesses. This Comment examines the critical role nonprofit healthcare bankruptcies play in safeguarding the health and well-being of communities, and explores the issues that have left debtors, creditors, the public, and courts frustrated.

The bankruptcy system must acknowledge public interests in health care and ensure the provision of essential healthcare services. By advocating for targeted modifications within the bankruptcy framework, this Comment promotes a more equitable and effective resolution for the complex issues surrounding healthcare bankruptcy proceedings.
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INTRODUCTION

Every day, Lachlan struggled to breathe. A kindergartner from Tulsa, Oklahoma with a connective tissue disorder, severe allergies and asthma, Lachlan regularly needed services that only a pediatric intensive care unit could provide. But in Tulsa, and all around the country, hospitals had been closing down pediatric units. By Lachlan’s sixth birthday, there remained only one hospital with an inpatient pediatric option in Tulsa, and Lachlan frequently camped out in the emergency room with his mother, fervently hoping for a bed.

Local access to children’s inpatient hospital care has been in decline for the past decade. According to the American Health Association, only 37% of hospitals offered pediatric care in 2020. A study published in 2021 indicates that most states have experienced declines in both the number of pediatric patient beds available in hospitals and the length of pediatric hospital stays. The justification is purely economic—provision of healthcare to sick adults is more profitable than provision of healthcare to sick children.

In places like Baltimore, Boston, Richmond, and Tulsa, hospitals electing to shut down their pediatric inpatient units has “eliminated the capacity to care for local children.” As a result, almost one-quarter of children in the United States are forced to travel farther from home to find pediatric inpatient beds.
This issue is especially acute in rural America, where children may be routinely traveling 100–200 miles within their own states to see a provider. Rural hospitals and healthcare systems provide essential access to health care in rural communities without requiring such travel. However, there has been a steady trend of people migrating away from rural areas in recent years, resulting in understaffed hospitals unable to meet patient quotas and rural communities without a single hospital or emergency department. Healthcare labor shortages, inflation, rising expenses, and diminishing hospital margins have made addressing such challenges difficult. Because of this, it is likely that community hospitals in financially disadvantaged towns will continue to close units—some, perhaps many, will declare bankruptcy.

Healthcare bankruptcy filings are also on the rise in the U.S., in part because of recent public health challenges like the COVID-19 Pandemic. According to Gibbins Advisors, a healthcare restructuring advisory firm, nearly three times the number of large healthcare bankruptcy filings occurred in the fourth quarter of 2022 compared to the first quarter of the same year. Overall, healthcare bankruptcy filings in 2022 increased by an alarming 84% from 2021. Increases in healthcare business bankruptcy filings have in turn decreased access to health care.

If a hospital or provider goes bankrupt in a way that does not allow for

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12 Zdanowicz, supra note 7 (“A lot of rural communities don’t have pediatricians . . . . Getting hospital care often means traveling outside the community.”).
14 Aallyah Wright, Rural Hospitals Can’t Find the Nurses They Need To Fight COVID, STATELINE (Sept. 1, 2021, 12:00 AM), https://stateline.org/2021/09/01/rural-hospitals-cant-find-the-nurses-they-need-to-fight-covid.
15 Id.; see Zdanowicz, supra note 7.
16 Krugman & Rauch, supra note 3.
19 Schiavo, supra note 18.
continuity of care, rural Americans—including critically-ill children—will have difficulties accessing health care.\footnote{See Zdanowicz, supra note 7 (“It’s bad, and it’s getting worse. Those safety net hospitals are the ones that are most at risk for closure . . ..”).}

The healthcare industry is unique in this respect; while it must reflect and respond to market pressures, the provision of health care is undoubtedly a necessity for which there is no substitute. The healthcare system continually evolves due to various factors such as legislation, technology, and demographics. Yet unlike other services, health care demands uninterrupted delivery to safeguard the health and well-being of any population. For this reason, bankruptcy proceedings should be conducted in a way that ensures continuity of care, especially for vulnerable populations like young Americans.

It is even more complicated for not-for-profit hospitals,\footnote{Fast Facts: U.S. Rural Hospitals Infographic, supra note 13.} which must abide by a charitable mission,\footnote{See, e.g., Manhattan Eye, Ear & Throat Hosp. v. Spitzer, 715 N.Y.S.2d 575, 593 (Sup. Ct. 1999) (“It is axiomatic that the board of directors is charged with the duty to ensure that the mission of the charitable corporation is carried out.”).} to continue to provide care or undergo bankruptcy. The intricate interplay among these three variables—health care businesses, rural communities, and nonprofit organizations—raises a vital question: does the bankruptcy system sufficiently safeguard health care access for vulnerable communities?

This Comment argues that the Bankruptcy Code (the “Code”)\footnote{The Code took effect on October 1, 1979. Pub. L. No. 95-598, 92 Stat. 2549. Its enabling legislation did not have an official title, but is often referred to as “The Bankruptcy Reform Act of 1978.” Eric A. Posner, The Political Economy of the Bankruptcy Reform Act of 1978, 96 Mich. L. Rev. 47, 48 n.3 (1997).} should have a role in securing health care delivery, but it is not well-suited to address the myriad complexities that arise from bankruptcies of nonprofit health care. Despite the 2005 Bankruptcy Abuse and Consumer Protection Act’s (“BAPCPA”)\footnote{The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 made substantial revisions to the Code. See Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA), Pub. L. No. 109-8, 119 Stat. 23.} attempts to tailor specific sections of the Code to health care needs, the Code fails to properly address nonprofit healthcare bankruptcies, particularly when the hospital at issue is in a rural community. This Comment suggests the Code should be amended to include a nonprofit health care business debtor provision that adds a definition of “essential health care services.” Such a definition would better equip the Code to ensure the continuity of care for vulnerable populations.
This Comment proceeds in four parts. Part I focuses on challenges facing the U.S. healthcare industry, their impact on rural America, and the complexities of health care business bankruptcies. Part II delves into nonprofit organizations, their origins, and explores the role of state attorneys general in representing the public’s interests. Part III assesses the function of charitable organizations, the presence or absence of clear support for charitable purpose in the Code, and highlights the Code’s inadequacy in addressing the needs of nonprofit health care businesses seeking bankruptcy protection. Finally, Part IV addresses the inherent conflict that exists between the fundamental principles of the bankruptcy and public interest systems. It advocates for amendments to the Code to balance the interests of creditors and debtors, but also prioritizes the welfare of the public. This Comment concludes by proposing reforms to the Code, emphasizing the need to address nonprofit health care businesses and standardize bankruptcy proceedings rather than leave them in the ambiguities of state law.

I. THE U.S. HEALTHCARE INDUSTRY TODAY

This Part focuses on the U.S. healthcare industry. Part I.A examines the industry’s significance within the U.S. economy and its complexities. Part I.B delves into the unique challenges faced by the healthcare sector in rural America. Lastly, Part I.C reviews the escalating trend of healthcare bankruptcies, exploring the intricacies that make them particularly difficult to navigate under the Code’s current framework.

A. Factors Affecting the Healthcare Industry

The U.S. healthcare industry is substantial and expensive in comparison to other domestic industries and healthcare spending in other nations. It is the largest industry by revenue, representing 18.3% of the U.S. economy. In 2021, healthcare spending in the U.S. reached $4.3 trillion and the gross domestic product (“GDP”) share dedicated to healthcare is projected to rise to $6.8 trillion by 2028.

28 Id. (“. . . US spent nearly 16.8% of gross domestic product (GDP) on healthcare in 2019. Germany was the second-highest ranking country, spending 11.7%, followed by Switzerland, spending 11.3.”).
29 Id.
30 Id.
The healthcare industry includes four main sectors: healthcare services and facilities; manufacturers of equipment and medical devices; medical insurance and managed care companies; and pharmaceutical development and marketing. This piece focuses primarily on the first sector, which will be referred to as “healthcare organizations.” Healthcare organizations are highly susceptible to financial distress—“a state of poor financial health” that “indicates that an organization is at risk of default and unable to meet its financial obligations.”

Many factors contribute to this susceptibility, such as high costs, uncompensated care, reimbursement rates, limited revenue sources, patient demographics, and the regulatory environment.

The cost of providing healthcare services is high, and competitive healthcare organizations must continually invest in new technology, facilities, and staff. Government programs like Medicaid and Medicare do not fully offset the cost of providing services, and so the cost of medical supplies and drugs is severe. Many healthcare organizations, especially those serving low-income and uninsured populations, often must provide care to patients without receiving payment. Naturally, this uncompensated care can place a significant strain on finances. Healthcare organizations also face reimbursement cuts and delays, making it difficult to budget and plan for the future. Healthcare organizations, especially nonprofit hospitals and clinics, often also rely heavily on fewer

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32 Note that the term “healthcare organization,” which is used throughout this Comment, is distinguished from “health care business,” a Code-specific term that is discussed in detail later. 11 U.S.C. § 101(27A). In this Comment, the term “healthcare organization” is broader than “health care business,” and is used to generally encapsulate all healthcare providers, organizations, and entities.


34 See Enumah & Chang, supra note 18, at 251–52, 257.


sources of revenue, such as patient charges or government funding.\textsuperscript{38} This creates more vulnerability to financial distress if that revenue source dissipates.\textsuperscript{39}

The healthcare industry is subject to heavy regulation at both the state and federal levels.\textsuperscript{40} Healthcare organizations must comply with a range of laws and regulations, increasing the cost of care. The sector is overseen by many agencies,\textsuperscript{41} and keeping pace with fluctuating regulations can be taxing, time-intensive, and costly.

In addition, the recent and sustained decline in the number of qualified healthcare professionals has been frequently identified as a pressing issue for the healthcare industry.\textsuperscript{42} The COVID-19 Pandemic and Great Resignation\textsuperscript{43} led to continuous demand exacerbated by a shortage of workers.\textsuperscript{44} Between February 2020 and January 2022, the Bureau of Labor Statistics reported a loss of 378,000 healthcare jobs,\textsuperscript{45} which in part reflects the chronic national nursing shortage.\textsuperscript{46}

\begin{footnotesize}
\footnote{39}{Cf. Enumah & Chang, supra note 18, at 254 (demonstrating that a larger share of hospital revenue from Medicaid services is associated with increased odds of financial distress).}
\footnote{40}{Robert I. Field, Why Is Health Care Regulation So Complex?, 33 PHARMACY & THERAPEUTICS 607, 607 (2008) (“A broad range of regulatory bodies and programs apply in different ways to various aspects of the industry. Health care regulations are developed and enforced by all levels of government—federal, state, and local—and also by a large assortment of private organizations. At times, they operate without coordination.”). The healthcare industry is impacted by numerous laws, including the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, the Emergency Medical Treatment and Labor Act, the Anti-Kickback Statute, Stark Law, and the Patient Safety and Quality Improvement Act of 2005, to name a few.}
\footnote{41}{Such agencies include the Centers for Disease Control, the Department of Health and Human Services, the Center for Medicare & Medicaid Services, and the Food and Drug Administration. See, e.g., Deryck A. Palmer & Michele J. Meises, Collision Course Between Bankruptcy and Health Care Laws: Which Will Ultimately Control?, 1999 NORTON ANN. SURV. BANKR. L. 1, 1–2.}
\footnote{42}{See generally Wright, supra note 14; Zdanowicz, supra note 7.}
\footnote{44}{See COVID-19 Unemployment and Job Losses, GEO. UNIV.: CTR. ON EDUC. & WORKFORCE, https://cew.georgetown.edu/cew-reports/jobtracker/#tool-3-tracking (last visited May 16, 2024).}
\end{footnotesize}
Significant labor cost increases exist, partially due to providers’ growing reliance on traveling nurses to meet their staffing needs. Hospital labor expenses have risen 37% from pre-Pandemic levels. Unfortunately, labor costs are rising while reimbursement costs are not.

B. How Rural America Is Faring

The effect of these challenges is most acute in rural America. Rural hospitals routinely face the worst hospital profit margins. Such hospitals encounter distinctive challenges, including low patient numbers, outdated infrastructure, geographic isolation, insufficient healthcare coverage, and more demanding patient demographics compared to urban areas.

Low patient volumes and fewer resources compared to urban hospitals make it difficult for rural hospitals to generate enough revenue to stay afloat. Recruiting and retaining qualified staff, such as physicians and nurses, can be especially difficult in rural areas where fewer job opportunities exist. Rural hospitals also have limited access to the latest technology and equipment, which

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48 Healthcare Bankruptcies Trending 25% Higher in 2022; Senior Care Most at Risk, supra note 46.


53 Levinson et al., supra note 51.

54 Zdanowicz, supra note 7.
affects the ability to provide high-quality care.\textsuperscript{55} Coordinating care is arduous without access to electronic records and other digital tools.

Geographic isolation also poses difficulty for rural hospitals.\textsuperscript{56} Isolation makes it taxing for patients to travel to receive care or find specialists.\textsuperscript{57} Lower population densities in rural areas make it difficult to generate adequate revenue and maintain operating costs. In turn, this impedes hospital participation in performance measurement and quality improvement activities.\textsuperscript{58} The patients themselves also present challenges: rural hospitals often serve older, sicker, and poorer patients with heightened healthcare needs, limited income, and higher uninsured rates.\textsuperscript{59} Further, rural hospitals heavily depend on government programs like Medicare and Medicaid, which often reimburse below the actual cost of care.\textsuperscript{60}

These challenging circumstances have contributed to a decline in the number of U.S. hospitals.\textsuperscript{61} Between March 2020 and June 2023, thirty-five rural hospitals closed.\textsuperscript{62} Fewer than half of the remaining open rural hospitals have the resources to staff a meager twenty-five beds, and fewer beds makes the management of overhead costs precarious.\textsuperscript{63} Although COVID-19 assistance provided some relief,\textsuperscript{64} rural hospitals remain financially at-risk. Nonprofit hospitals are also employing tactics typically seen in for-profit hospitals to increase profit margins.\textsuperscript{65} These are clear indicators of financial distress.

\begin{itemize}
\item \textsuperscript{55} See id.
\item \textsuperscript{56} See id.
\item \textsuperscript{58} Rural Hospital Closures Threaten Access: Solutions To Preserve Care in Local Communities, AM. HOSP. ASS’N (Sept. 2022), https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
\item \textsuperscript{59} Id.; Johnson, supra note 57.
\item \textsuperscript{60} Ahmed, supra note 38; Cunningham et al., supra note 36.
\item \textsuperscript{61} See Fast Facts: U.S. Rural Hospitals Infographic, supra note 13 (demonstrating that between 2017 and 2021, the number of U.S. community hospitals declined, 71\% of which were rural hospitals).
\item \textsuperscript{62} Johnson, supra note 57.
\item \textsuperscript{63} Fast Facts: U.S. Rural Hospitals Infographic, supra note 13.
\end{itemize}
Crucially, one out of every five Americans depends on their community hospital as their primary, and often only, source of accessible medical care.\textsuperscript{66} Community hospitals represent the vast majority of the country’s hospitals, nearly 60\% of which are private nonprofit hospitals.\textsuperscript{67} Presently, nearly 46 million people residing in rural areas across the U.S.—representing 14\% of all Americans—face a significant shortage of healthcare services.\textsuperscript{68}

Rural communities experience higher death rates, have lower levels of socioeconomic status, and a higher prevalence of substance use and mental illness needs.\textsuperscript{69} The communities suffering these negative outcomes also have a higher proportion of military veterans than urban areas.\textsuperscript{70} Notwithstanding lack of health care access, children in rural communities are also at higher risk for certain poor health outcomes.\textsuperscript{71} Hospitals that serve these vulnerable populations are at the highest risk of closing.\textsuperscript{72} Therefore, the bankruptcy system must better address the impact of financial distress in affecting health care continuity.

C. Healthcare Organizations Are Increasingly Filing for Bankruptcy

The U.S. has witnessed an upsurge of health care business bankruptcy filings in recent years. In 2022, chapter 11 bankruptcy filings for large healthcare organizations were 28\% higher than in the previous year.\textsuperscript{73} Healthcare organizations filing for bankruptcy must consider several factors and competing interests. These organizations must assess their current state of operations, contracts with payor networks, their physicians, patients, suppliers, and government programs like Medicaid and Medicare.\textsuperscript{74} The bankruptcy process can be convoluted and time-consuming, with healthcare organizations often


\textsuperscript{68} See \textit{Rural Hospital Closures Threaten Access: Solutions To Preserve Care in Local Communities}, supra note 58 (stating that 84\% of U.S. hospitals are community-based).

\textsuperscript{69} Jarron M. Saint Onge & Sarah Smith, \textit{Demographics in Rural Populations}, SURGICAL CLINICS N. AM. 823, 826–30 (2020).

\textsuperscript{70} Id.

\textsuperscript{71} Id. at 830.


managing competing claims from creditors.\textsuperscript{75} Further, providers may need to restructure operations during bankruptcy, including reducing costs, staff reductions, or facility closures, leading to difficult decisions and negative impacts on employees and patients. The bankruptcy process may lead to the sale of assets, such as hospitals or clinics, which can have an adverse effect on the community.\textsuperscript{76} These factors hinder the ability of healthcare organizations to emerge financially stable after bankruptcy.

Health care businesses can file for bankruptcy under several chapters of the Code. Nonprofit healthcare organizations can opt for chapter 7, which involves the liquidation of assets to pay off creditors.\textsuperscript{77} If a municipality is involved, such as when a community hospital is run by the local government, chapter 9 bankruptcy is applicable.\textsuperscript{78} There is also the traditional chapter 11 option, which permits reorganization of a business.\textsuperscript{79}

Part I.C.1 reviews provisions in the Code that are applicable to health care business bankruptcies, and Part I.C.2 analyzes how the Code’s stipulations can lead to inconsistent application of bankruptcy principles, which adversely affects debtors.

1. \textit{BAPCPA’s Provisions Relevant to Health Care Businesses}

The 2005 BAPCPA amendments to the Code included healthcare-specific provisions that were a respectable step towards altering the bankruptcy practices

\textsuperscript{75} See 11 U.S.C. § 1122(a); see also 11 U.S.C. §§ 1123(a), 1322(b)(1). A reorganization plan must designate classes of claims or interests, which can be time-consuming due to factors such as significant asset amounts, numerous creditors, and disputes over the priority or treatment of claims. A plan can help debtors manage claims from creditors in a fair and nondiscriminatory manner.

\textsuperscript{76} See generally George M. Holmes et al., \textit{Underserved Populations: The Effect of Rural Hospital Closures on Community Economic Health}, 41 HEALTH SERVS. R SCH. 467 (2006).

\textsuperscript{77} See 11 U.S.C. § 109(b) (defining debtor eligibility for chapter 7 bankruptcy). Chapter 7 cases are often referred to as “straight” bankruptcies, in which the debtor’s non-exempt assets are collected by a trustee who identifies, collects, liquidates, and distributes them.

\textsuperscript{78} See 11 U.S.C. § 109(c) (defining debtor eligibility for chapter 9 bankruptcy); 11 U.S.C. § 101(40) (defining “municipality” for chapter 9 eligibility as a “political subdivision or public agency or instrumentality of a State.”).

\textsuperscript{79} See 11 U.S.C. §109(d) (defining debtor eligibility for chapter 11 bankruptcy); see also 11 U.S.C. §§ 1107–1108 (explaining that through the commencement of a chapter 11 case, a debtor attempts to reorganize itself by proposing a plan of reorganization that provides a satisfactory schedule of payments and possibly collateral to its debtors, and typically remains in business). For a thorough review of chapter 11 issues, see generally Bruce A. Markell, \textit{The Sub Rosa Subchapter: Individual Debtors in Chapter 11 After BAPCPA}, U. ILL. L. REV. 67 (2007).
of health care businesses. BAPCPA made several notable changes, including creating the role of patient care ombudsman to ensure patient care quality and to “protect vulnerable patients from inequities that arise during the bankruptcy process.”

Another provision allows for the disposal of patient records in cases where the estate does not “have a sufficient amount of funds to pay for the storage of patient records in the manner required under applicable Federal or State law.” Other new requirements include constraints placed on bankruptcy trustees (including debtors-in-possession) when transferring patients.

Of particular interest is section 101(27A) of the Code, which defines “health care business” to encompass a wide range of institutions providing medical care, such as hospitals, surgical facilities, nursing facilities, hospices, and assisted-living facilities. However, this definition excludes some healthcare organizations because certain healthcare providers fall outside the criteria outlined in the Code. This Comment applies the section 101(27A) definition when referring to a “health care business.”

Section 362 also has unclear implications. This section contains a specific provision allowing the Secretary of Health and Human Services to exclude facilities from Medicare and recover prepetition payments, bypassing the automatic stay. This provision has led to questions on whether the automatic stay prohibits government authorities from recouping pre-bankruptcy overpayments. It is important to underscore the vital importance of this issue. The automatic stay is a fundamental debtor protection that temporarily prevents creditors, collection agencies, and the government from trying to collect money

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82 Kevin A. Spainhour, Comment, Statutory Quixotics: Tilting Against the Health Care Business Amendments to the Bankruptcy Code, 24 EMORY BANKR. DEV. J. 193, 197 (2008).
84 For a description of the chapter 11 trustee’s responsibilities, see 11 U.S.C. § 704(a)(12), and for the debtor-in-possession’s responsibilities, see 11 U.S.C. § 1106(a)(1).
85 See Coordes, supra note 33, at 433 (“Accountable Care Organizations (ACOs) are a prominent example of healthcare institutions with an uncertain bankruptcy eligibility status.”).
86 See Forum, The Healthcare Industry Bankruptcy Workouts Forum, 8 AM. BANKR. INST. L. REV. 5, 43 (2000) (stating that certain healthcare companies were ineligible for bankruptcy because they were more like insurance companies than traditional business enterprises).
or seize property from debtors in bankruptcy under section 362 of the Code.\footnote{11 U.S.C. § 362.} As this Comment next explores, a seemingly semantic discussion on the principle of ‘recoupment’ and how it compares to ‘setoff’ is significant because of how it affects automatic stay protections.

2. Case Analysis: The Recoupment Doctrine and the Automatic Stay

In recent years, courts have established that the automatic stay bars government authorities from recouping prepetition overpayment claims or other debts from postpetition Medicaid or Medicare program disbursements.\footnote{See, e.g., True Health Diagnostics, LLC v. Azar, 392 F. Supp. 3d 666, 687–89 (E.D. Tex. 2019). A bankruptcy court ruled that the automatic stay exception did not apply because evidence showed the government withheld the payments to prioritize financial concerns, with no indication of serving public interests.} A particularly notable example arose in the United States Court of Appeals for the Ninth Circuit.\footnote{Gardens Reg’l Hosp. & Med. Ctr., Inc. v. California (In re Gardens Reg’l Hosp. & Med. Ctr., Inc.), 2018 WL 1354334, at *4–6 (B.A.P. 9th Cir. Mar. 12, 2018), aff’g 569 B.R. 788 (Bankr. C.D. Cal. 2017).} In In re Gardens Regional Hospital and Medical Center, the debtor, Gardens Regional Hospital, filed for chapter 11 bankruptcy in June 2016.\footnote{Gardens Reg’l Hosp., 975 F.3d 926.} Following the debtor hospital’s bankruptcy petition, the State of California detected that the hospital had failed to pay certain state specific “fees” and deducted those fees from the payments owed to the hospital under Medicaid.\footnote{Id. at 931.} The hospital moved for the funds to be returned, alleging that the State’s action constituted an “impermissible setoff” that violated the automatic stay protection.\footnote{See id. at 931; see 11 U.S.C. § 553(a) (defining setoff).}

Although the Bankruptcy Appellate Panel (“BAP”) and bankruptcy court agreed that the deducted fees constituted recoupment, rather than setoff,\footnote{Gardens Reg’l Hosp. & Med. Ctr., Inc. v. California (In re Gardens Reg’l Hosp. & Med. Ctr., Inc.), 2018 WL 1354334, at *4–6 (B.A.P. 9th Cir. Mar. 12, 2018), aff’g 569 B.R. 788 (Bankr. C.D. Cal. 2017).} the Ninth Circuit partially overturned the lower courts’ decision.\footnote{Gardens Reg’l Hosp., 975 F.3d at 940.} This reversal allowed California to recoup the unpaid fees through one of the payment sources.\footnote{See id. at 938–39 (“We reach the opposite conclusion with respect to California’s deduction of the unpaid HQAF [hospital quality assurance fee] assessments from the fee-for-service payments made to Gardens Regional. [These] deductions [constituted] a setoff that is subject to the restrictions of the Bankruptcy Code and not a permissible equitable recoupment.”). The Ninth Circuit considered the deduction of unpaid HQAF assessments separate from HQAF supplemental payments acceptable under recoupment. However, it regarded the deductions of unpaid HQAF assessments from fee-for-service payments as originating from a different payment source and deemed them as setoffs.} To reach this conclusion, the Ninth Circuit discussed the principles of
recoupment and setoff. The court defined setoff as a common law principle that enables mutual debts to offset each other, even from distinct transactions, and thus falls under the automatic stay under section 362(a)(7). Conversely, recoupment is an equitable concept that applies when a debtor’s and creditor’s claims stem from the same transaction, rather than as an adjustment of separate mutual debts; recoupment is not impacted by the automatic stay. The Ninth Circuit also identified the difficulty lower courts have in applying the distinction of what qualifies as “the same transaction or occurrence.” This test has received criticism as being “too ambiguous to be uniformly applied.”

Medicaid payments were implicated in Gardens Regional Hospital. The Medicaid program is a vital reimbursement stream for rural hospitals and pediatric patients, offering coverage to more than half the children in the country. Inconsistent application of the recoupment doctrine in healthcare bankruptcy cases and subsequent implications to automatic stay protection is a predicament for distressed healthcare businesses. This inconsistency has the potential to impact certain communities because of how it can affect essential payment streams, such as Medicare and Medicaid payments.

A debtor healthcare organization should know whether it will be granted the important automatic stay protection when evaluating its options before filing for bankruptcy. Leaving this issue up for debate can make bankruptcy proceedings daunting, financially cumbersome, and contrary to public policy.

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99 See Gardens Reg’l Hosp., 975 F.3d 926.
100 Id. at 932–33; see also 11 U.S.C. §§ 362(a)(7), 553(a).
101 Gardens Reg’l Hosp., 975 F.3d at 933–35. See generally Sims v. U.S. Dep’t of Health & Hum. Servs. (In re TLC Hosps., Inc.), 224 F.3d 1008, 1011 (9th Cir. 2000) (stating that the differences between recoupment and setoff are important within the bankruptcy context).
103 See Gardens Reg’l Hosp., 975 F.3d at 931.
104 Zdanowicz, supra note 7; see Levinson et al., supra note 51.
105 See Coordes, supra note 33, at 438 (articulating that the issue of whether bankruptcy courts have the authority to resolve Medicare or Medicaid disputes is not clear); see also True Health Diagnostics, LLC v. Azar (In re THG Holdings, LLC), 604 B.R. 154 (Bankr. D. Del. 2019) (determining that the state’s withholding of Medicare and Medicaid payments was not exempted from the automatic stay).
II. NONPROFIT ORGANIZATIONS AND STATE ATTORNEYS GENERAL

The purpose of a nonprofit organization is defined by its charitable mission statement, which guides the organization’s decision-making. Nonprofits have a responsibility to uphold the duties of care, loyalty, and obedience to the charitable mission of the organization. If the charitable purpose of a nonprofit hospital is not met, a court can, for example, deny the sale of assets on such grounds. Nonprofit organizations may file for protection under both chapter 7 and chapter 11 of the Code, but chapter 11 is “designed for and is predominantly applied to for-profit entities’ structure and business objectives,” which can create complexities for nonprofits that may be more suited to chapter 11 proceedings.

Generally, Part II discusses the U.S. nonprofit sector and its experience with bankruptcy. Part II.A first reviews the role of nonprofits within the U.S. economy and reviews bankruptcy law relevant to nonprofits. Part II.B examines the role of state attorneys general in nonprofit bankruptcy proceedings and considers their constraints.

A. Nonprofits and the U.S. Economy

The nonprofit sector represents a sizable portion of the U.S. economy, making up 5.9% of the 2020 GDP, and contributing $1.4 trillion to the U.S. economy by the third quarter of 2022. In recent years, nonprofits have suffered from a disruption of programs and funding, and 40% of nonprofit

\[\text{References}\]


107 Linda Schechter Manley, Debt Restructuring for Tax-Exempt Charitable Organizations, 22 TAX’N EXEMPTS 12, at *13 (2011). The board members of a nonprofit corporation have a fiduciary duty to guarantee that charitable assets are utilized for their intended purposes and to fulfill the organization’s mission effectively. In cases of insolvency, the board has a fiduciary obligation to both the organization’s clients and its creditors. See Nancy A. Peterman & Sherri Morissette, Directors’ Duties in the Zone of Insolvency: The Quandary of the Nonprofit Corp., 23 AM. BANKR. INST. L. REV. 12 (2004).

108 See Spitzer, 715 N.Y.S.2d at 593 (“It is axiomatic that the Board of Directors is charged with the duty to ensure that the mission of the charitable corporation is carried out. This duty has been referred to as the ‘duty of obedience.’”).


111 Id. at 3.

organizations have reported an overall loss in total revenue.\textsuperscript{113} Nonprofits in large U.S. cities and rural areas have also reported experiencing a steeper decline in earned revenue compared to those in smaller cities and suburban areas.\textsuperscript{114} Nonprofit organizations are also known to suffer from “all of the same problems as for-profit corporations.”\textsuperscript{115} Considering how the nonprofit sector forms the foundation of a civil society and healthy, equitable communities, the recent trend of nonprofit healthcare insolvencies merits further examination.\textsuperscript{116}

Although established legal precedents\textsuperscript{117} and state laws\textsuperscript{118} acknowledge that the charitable contributions nonprofit organizations receive must be used as intended, the term “nonprofit” remains curiously undefined in the Code. Instead, the Code refers to “a corporation that is not a moneyed, business, or commercial corporation.”\textsuperscript{119} This phrase is itself not well-defined either, leaving courts frustrated.\textsuperscript{120} Conventionally, the Internal Revenue Code (“I.R.C.”) definition is referenced in the context of bankruptcy to identify nonprofit status, under which charitable organizations are typically nonprofit entities organized and operated for “charitable, religious, educational, scientific, literary, testing for public safety, . . . and preventing cruelty to children or animals.”\textsuperscript{121}

\begin{footnotes}
\textsuperscript{113} Health of the U.S. Nonprofit Sector, supra note 110, at 10. In 2020, 57% of nonprofits decreased overall expenses, 64% suspended or paused services at some point, 44% reduced the number of programs or services, and 47% served fewer people by the end of the year.
\textsuperscript{114} Id. at 11.
\textsuperscript{116} See Samuel R. Maizel & Mary D. Lane, The Sale of Nonprofit Hospitals Through Bankruptcy: What BAPCPA Wrought, AM. BANKR. INST. J., June 2011, at 12 (“A significant percentage of America’s hospitals are nonprofit hospitals, and . . . are significantly weaker financially than their for-profit peers. Because of the likelihood of nonprofits being financially weak and having to merge, potentially with for-profit hospital chains, the rules governing the acquisition of a nonprofit hospital by a for-profit entity will become more important commercially.”). See In re United Healthcare Sys., Inc., No. 97-1159 (NHP), 1997 WL 176574 (D.N.J. Mar. 26, 1997) (holding that a bankruptcy court must consider the public’s interests when handling the transfer of a nonprofit hospital’s assets).
\textsuperscript{118} See, e.g., CAL. CORP. CODE § 5917(e) (West) (“The proposed use of the proceeds from the agreement or transaction is consistent with the charitable trust on which the assets are held by the health facility or by the affiliated nonprofit health system.”).
\textsuperscript{119} 11 U.S.C. § 303(a) (specifying that an involuntary petition cannot be filed against a corporation that is not a moneyed, business, or commercial entity).
\textsuperscript{120} See, e.g., Grace Christian Ministries, Inc. v. Quinn (In re Grace Christian Ministries, Inc.), 287 B.R. 352, 355–56 (Bankr. W.D. Pa. 2002) (grappling with whether a debtor who registered as a nonprofit entity but involved for-profit ventures was eligible for the section 303(a) exception). See generally Hollander & Brown, supra note 115.
\textsuperscript{121} I.R.C. § 501(c)(3); see also Foohey, supra note 109, at 32 n.1 (“For example, Title 11 of the United States Code . . . does not define ‘nonprofit.’ The term, however, is generally understood to include any
Commentators have also noticed that bankruptcy “law has failed to furnish guidance on the bedrock questions surrounding accountability and mission” when reviewing “transactions that implicate [a] nonprofit enterprise’s purpose.” Nevertheless, the Code contains few provisions addressing charitable nonprofit organizations undergoing bankruptcy, including their protection from liquidation and the creation of charitable trusts.

If nonprofits meet the Code’s requirements, they are generally protected during bankruptcy proceedings. As will be later discussed, interpreting the Code’s ambiguities has proven arduous. Next, however, this Comment provides a brief review of laws relevant to nonprofit debtors and specific nonprofit bankruptcy provisions derived from BAPCPA.

1. Bankruptcy Law Relevant to Nonprofits

Predating BAPCPA, there are important nonprofit-relevant bankruptcy provisions in effect. In 1998, Congress enacted the Religious Liberty and Charitable Donation Protection Act. This Act ensured that religious and charitable organizations would not be required to return any contributions made by a donor who later declared bankruptcy. It protects prepetition charitable donations from being attacked as a constructively fraudulent transfer if the donation meets certain criteria. The Religious Liberty Act generated conflicting reactions from the philanthropic and bankruptcy community.

Additional protections exist for nonprofit debtors. Certain courts argue that the absolute priority rule, designed to safeguard creditors in cramdown plans,
need not be enforced for nonprofit entities, as they do not receive profits or distributions. Courts ruling on contested reorganization plans of nonprofit entities have held that debtor nonprofit corporations owning hospitals are not subject to the absolute priority rule, which can protect charitable assets from being liquidated to pay off other creditors.

Further, creditors may not place certain nonprofit entities in bankruptcy through an involuntary petition. In addition, a bankruptcy court is prohibited from converting a chapter 11 case to chapter 7 if the debtor is a nonprofit. By implementing these safeguards within the Code, Congress aimed to shield churches, schools, foundations, and nonprofits from involuntary bankruptcy proceedings.

2. BAPCPA Provisions Relevant to Nonprofits

BAPCPA also aimed to protect nonprofit organizations and had a direct impact upon the sale of assets by charitable entities that filed for bankruptcy. Section 1221 of BAPCPA governs the transfers of charitable assets made by nonprofit charitable organizations. Specifically, section 1221 amended Code sections 363, 541, and 1129 to create a greater role for a state and its attorney general in dealing with charitable assets in bankruptcy proceedings to support public policy considerations. These amendments were meant to limit the ability of a nonprofit debtor to transfer assets, but not more so than under non-bankruptcy law.

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128 See, e.g., In re Wabash Valley Power Ass’n, Inc., 72 F.3d 1305, 1319, 1320 (7th Cir. 1995).
130 See 11 U.S.C. § 303(a). Section 303(a) prevents an involuntary case from being commenced against a corporation that is not a moneyed, business or commercial corporation—meaning that this section prevents creditors from placing nonprofit entities into bankruptcy and thus protects nonprofit health care businesses.
131 See 11 U.S.C. § 1112(c). The Code uses the same language as is used in section 303(a) to indicate that nonprofit entities are not subject to conversion from chapter 11 to 7.
134 BAPCPA § 1221.
135 See id. § 1221(a); see also 11 U.S.C. §§ 363(d), 541(f), 1129(a)(16). The aforementioned BAPCPA amendments require that certain bankruptcy actions, e.g., the sale or transfer of assets of a nonprofit debtor, be made in accordance with applicable non-bankruptcy law. Non-bankruptcy law is, in effect, a reference to state law. Because state law constructs a specific role for the state’s attorney general in handling nonprofits, those state laws are then incorporated into the Code.
136 See BAPCPA § 1221(a).
BAPCPA revised section 363(d) to limit the trustee’s power to handle property owned by nonprofit corporations or trusts.\textsuperscript{137} Rather, any use, sale, or lease under subsections (b) and (c) must adhere to non-bankruptcy laws governing nonprofit property transfers, given they do not conflict with the automatic stay provisions of section 362.\textsuperscript{138}

Section 1221 also imposed comparable restrictions on plan confirmation cases under chapter 11.\textsuperscript{139} BAPCPA modified section 541, specifying that any property belonging to a nonprofit debtor, as defined by I.R.C. § 501(c)(3), “may be transferred to an entity that is not such a corporation, but only under the same conditions that would apply if the debtor was not in bankruptcy.”\textsuperscript{140} In addition, section 1129(a)(16) requires courts to ensure that all property transfers under the plan comply with applicable non-bankruptcy laws regulating nonprofit entity property transfers before confirming the plan.\textsuperscript{141}

While these provisions indicate legislative interest in protecting certain communities and institutions, these protections lack clarity in practice. As explored next, the role of the state attorney general, while meant to represent the needs of the public, is frustratingly murky.

\textbf{B. The Role of the State Attorney General}

Both common law and statutory authorization provide the state, acting through its attorney general, with the power to administer proceedings to protect the public’s interests in charitable organizations. The state attorney general serves as an advocate for the “public interest in charitable trusts.”\textsuperscript{142} This role has developed because of the charitable nature of nonprofit organizations, which are created and operate with the primary objective of accomplishing beneficial outcomes for the community. States have historically supported the state attorney general’s authority over nonprofit board decision-making to promote

\textsuperscript{138} \textit{See 11 U.S.C. § 363(d).}
\textsuperscript{139} \textit{BAPCPA § 1221(b); see also H.R. REP. NO. 109-31(I), at 145.}
\textsuperscript{141} \textit{See 11 U.S.C. § 1129(a)(16).}
and safeguard the public’s needs.\textsuperscript{143} State attorney general oversight extends to structural changes affecting the status of nonprofit hospitals and claims of nonprofit mismanagement.\textsuperscript{144}

States have also enacted procedures under the purview of attorney general authority that charitable organizations must follow when selling, merging, or consolidating assets. States such as Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont have all delegated general statutory authority to the state attorney general, outlining the responsibilities of overseeing, administering, and enforcing “charitable trusts.”\textsuperscript{145}

A charitable trust is a type of trust established for charitable purposes, such as providing education, medical care, or other forms of assistance to those in need.\textsuperscript{146} In a bankruptcy proceeding, a charitable trust can be a valuable tool for protecting assets that are held for charitable purposes because the Code provides certain protections for charitable trusts.\textsuperscript{147}

Assets that are held in a charitable trust should, in theory, be protected from liquidation, as the trust’s purpose is to provide for charitable activities, rather than to benefit the debtor or the debtor’s creditors.\textsuperscript{148} Likewise, under the Code, charitable organizations are protected from liquidation in bankruptcy proceedings because of their special status as nonprofit organizations, their charitable activities, and the benefits they provide to the community. However, commentators have noted that the role of state attorneys general in the oversight of charitable assets is ambiguous.\textsuperscript{149}

\textsuperscript{143} See, e.g., Spitzer, 715 N.Y.S.2d at 592–93.
\textsuperscript{144} Greaney & Boozang, supra note 122, at 2.
\textsuperscript{146} Restatement (Third) of Trs. § 28 (Am. L. Inst. 2003).
\textsuperscript{147} See, e.g., 11 U.S.C. § 1129(a)(16) (“All transfers of property under the plan shall be made in accordance with any applicable provisions of non-bankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust.”); Salisbury v. Ameritrust Tex., N.A. (In re Bishop Coll.), 151 B.R. 394, 398 (Bankr. N.D. Tex. 1993) (describing charitable trusts as property that remains outside of the bankruptcy estate).
\textsuperscript{148} See Restatement (Third) of Trs. § 28 (Am. L. Inst. 2003).
\textsuperscript{149} Greaney & Boozang, supra note 122, at 4 (“[W]e question whether in its current unsettled and ambiguous state, the law can adequately guide [state attorneys general’s] actions.”); see also Lloyd Hitoshi Mayer, Fragmented Oversight of Nonprofits in the United States: Does It Work? Can It Work?, 91 Chi.-Kent L. Rev. 937, 941 (2016) (discussing states’ differing approaches on how and whether state attorneys general exercise oversight authority on nonprofits).

Although BAPCPA created a greater role for a state and its attorney general to handle charitable assets in bankruptcy proceedings through section 1221, the scope of an attorney general’s role remains unclear. This is especially prominent in the context of section 363 sales.\textsuperscript{150} In 2018, a nonprofit debtor, Verity Health Systems of California, Inc. (“Verity”), filed for bankruptcy under chapter 11.\textsuperscript{151} The California Attorney General (“AG”) initially approved the sale of the Verity hospitals contingent upon a restructuring agreement that required the hospitals being sold to “maintain specified levels of emergency services, intensive care services, cardiac services, and various other services.”\textsuperscript{152} The restructuring agreement included multiple conditions designed to apply to both current and future hospital owners.\textsuperscript{153} When Verity proposed to sell the hospitals “free and clear” of these conditions, the AG protested, “contending that the Conditions remained binding upon any purchaser of the Hospitals.”\textsuperscript{154}

The bankruptcy court disagreed with the AG, and concluded that the AG lacked the statutory authority to enforce the aforementioned conditions.\textsuperscript{155} To reach this conclusion, first, the bankruptcy court determined the conditions the AG imposed qualified as an “interest in property,”\textsuperscript{156} under the meaning of section 363(f)(1), which permits the sale of nonprofit entities free and clear of “any interest in such property.”\textsuperscript{157} Second, the court held that “applicable non-bankruptcy law” applied to the sale under section 363(d)(1), which allowed the sale to be governed by California state law.\textsuperscript{158} Finally, the bankruptcy court determined that the sale of a nonprofit health facility’s assets to a public entity was exempt from attorney general oversight because the buyer did not have private for-profit status.\textsuperscript{159}

This case illustrates several key points. First, despite the Code’s intent to expand the authority of the state attorney general in nonprofit bankruptcy proceedings,\textsuperscript{160} this case demonstrates a limit on a state attorney general’s

\textsuperscript{150} See, e.g., In re Verity Health Sys. Cal., Inc., 598 B.R. 283 (Bankr. C.D. Cal. 2018).
\textsuperscript{151} Id. at 287.
\textsuperscript{152} Id. at 288.
\textsuperscript{153} Id.
\textsuperscript{154} Id.
\textsuperscript{155} Id. at 296.
\textsuperscript{156} Id. at 292–93.
\textsuperscript{157} Id. at 292; see also 11 U.S.C. § 363(f)(1).
\textsuperscript{158} Verity, 598 B.R. at 293–94.
\textsuperscript{159} Id. at 294–95.
\textsuperscript{160} See supra Part II.A.2 for a discussion on BAPCPA’s nonprofit-relevant provisions.
authority to review nonprofit hospital sales in certain contexts. Second, the court’s holding restricts a state attorney general from enforcing future obligations on charitable assets involved in the transaction through application of section 363(f). In doing so, the bankruptcy court contradicted the AG’s efforts in safeguarding the nonprofit hospital systems’ charitable purpose. Third, while an entity’s nonprofit status triggers a state attorney general’s regulatory oversight, that oversight is unnecessary once the assets are transferred from the nonprofit entity to another entity.

2. **Case Analysis: In re Gardens Regional Hospital and Medical Center, Inc.**

Another case that restricted the state attorney general’s authority to supervise the sale of charitable assets is *In re Gardens Regional Hospital and Medical Center Inc.* Gardens Regional Hospital, a nonprofit hospital, pursued a section 363 sale to a for-profit entity, and the California AG consented, provided the buyer agreed to certain conditions. These financially significant conditions required, in part, that the prospective buyer would provide charity care and community benefits for six years. Gardens Regional Hospital sought modifications to these conditions, which the AG denied; eventually, the sale did not occur and the hospital ceased operations.

Subsequently, Gardens Regional Hospital pursued another sale, this time as a closed hospital, which the bankruptcy court expressly approved free and clear of the AG’s previous conditions under section 363(d)(1). Like the court in *Verity*, the bankruptcy court determined that the AG’s supervisory authority was not needed for two main reasons. First, hospital assets could be sold “free and clear” under section 363(f)(1), rendering the AG’s supervision unnecessary. Second, the court scrutinized the definition of “health facility” under California Health and Safety Code section 1250 and concluded that a

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161 See generally Verity, 598 B.R. 283.
162 See id. at 286–87.
164 Id. at 823.
165 Id. (noting that the conditions imposed by the state Attorney General would increase the “acquisition cost by approximately $21 million.”).
166 Id. at 823–24.
167 Id. at 824–25, 828 (explaining that the price of the original sale was approximately $19.5 million and the price of the second sale was approximately $6.6 million).
170 *CAL. HEALTH & SAFETY CODE § 1250* (West).
nonoperating closed hospital was not under the purview of the AG’s supervisory authority. 171

Ultimately, this case reiterates the pitfalls of a bankruptcy system that absolves itself of the responsibility of providing clear statutory guidance in nonprofit debtor cases. In *Gardens*, the bankruptcy court applied relevant non-bankruptcy state law to restrict the state attorney general’s authority to oversee the sale of a closed nonprofit hospital’s assets. Despite BAPCPA’s section 1221 provisions expanding the power of a state attorney general to oversee the sale of assets of charitable entities, the court prevented the California AG from exercising that same power.

As evidenced by *Verity* and *Gardens*, the Code has allowed for loophole interpretations that curtail a state attorney general’s authority to regulate the sale of charitable assets. By doing so, the bankruptcy system effectively limits the utility of nonprofit organizations and the benefits they provide to the public. Such decisions also raise critical questions about who supervises charitable assets after a sale, and who is ultimately responsible for upholding the charitable mission of a nonprofit organization.

III. NONPROFIT HEALTHCARE ORGANIZATIONS AND THEIR HEIGHTENED NEEDS

This Comment thus far has separately examined healthcare organizations and nonprofit organizations, emphasizing their roles in society, current financial landscapes, and their respective difficulties with the bankruptcy process. As discussed, bankruptcy proceedings are not without confusion, often posing unexpected barriers for all parties involved, including courts. When a debtor is a nonprofit healthcare organization, bankruptcy proceedings become even more convoluted.

Part III highlights the overarching dilemma encountered by bankruptcy courts when navigating the intersection of bankruptcy law and the sale of assets belonging to nonprofit healthcare debtors. The clash between the Code and applicable non-bankruptcy law introduces complex issues, leaving courts to balance the interests of creditors, debtors, the duties of a nonprofit organization’s board, and the organization’s charitable mission. This ambiguity plunges

171 *Gardens Reg’l Hosp.*, 567 B.R. at 827–30 (“Applying these principles of statutory construction, the [Bankruptcy] Court finds that the Assets being sold do not qualify as a ‘health facility’ within the meaning of Cal. Corp. Code § 5914(a) or Cal. Health & Safety Code § 1250.”).
bankruptcy courts into a guessing game, amplifying the frustration and complexity of the decision-making process. Importantly, these decisions most affect the party with the least say in the matter—the public.

A. The Origins of Nonprofit Healthcare Organizations and Tax-Exemption

The eighteenth century ushered in separate healthcare provider systems, which catered to the underprivileged and privileged through distinct funding streams.172 By the nineteenth century, a new type of hospital had emerged in the U.S., known as the “voluntary hospital.”173 Larger voluntary hospitals served lower-income populations and were supported by philanthropic contributions; conversely, smaller, physician-owned hospitals generally offered their services to wealthier self-paying clients.174

With the 1965 passage of Medicare and Medicaid,175 the U.S. government initiated a larger role in supporting marginalized communities and helped establish the modern healthcare system.176 Today, nonprofit hospitals comprise a large portion of all U.S. hospitals and represent significant sums in charitable assets.177 The role of healthcare organizations in the U.S. economy and society is unquestionably immense, and the bankruptcy system should befittingly support this role.

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173 STARR, supra note 172, at 150 (“In 1752 the Pennsylvania Hospital in Philadelphia became the first permanent general hospital in America built specifically to care for the sick; it was followed by New York Hospital, chartered in 1771, but not opened until twenty years later, and the Massachusetts General Hospital, opened in Boston in 1821. These were later to be called “voluntary” hospitals—voluntary because they were financed by voluntary donations rather than taxes.”).
176 STARR, supra note 172, at 373 (“The social programs of the 1960s were aimed at alleviating minority poverty; the health programs were aimed specifically at reducing the exclusion from medical care of the poor and the aged, who were marginal to the core sectors of the economy where health insurance was available as a fringe benefit.”).
177 Fast Facts: U.S. Hospitals Infographics, AM. HOSP. ASS’N (Jan. 18, 2024), https://www.aha.org/infographics/2024-01-18-fast-facts-us-hospitals-infographics (showing that 58% of U.S. hospitals are nonprofit); see also Where Did the Generosity Come from?, GIVING USA (June 2022), https://givingusa.org/wp-content/uploads/2022/06/GivingUSA2022_Infographic.pdf (noting that, in 2021, $40.58 billion in donations were made to the healthcare sector).
As philanthropic healthcare organizations came to be recognized by the state over time, organizations that met certain requirements were afforded income tax exemptions. Scholars have explained that “the overarching rationale behind granting nonprofit entities exemption from taxation [was] based on the public policy decision that by not taxing these entities, the government [did] not inhibit activities beneficial to the community and public interests.”

Section 501(c)(3) of the I.R.C. lists the criteria of tax exemption, specifying that an organization that is operated exclusively for religious, charitable, educational, scientific, literary purposes, or for public safety, is eligible. Although “hospitals are not specifically enumerated in § 501(c)(3),” healthcare organizations such as nonprofit hospitals may nonetheless receive the benefits. For nonprofit hospitals to be eligible for tax exemption, a community benefit must be demonstrated. Only by meeting this community benefit standard will a nonprofit hospital be deemed sufficiently “charitable” under the I.R.C. to receive exemption.

The organization must also meet operational and organizational criteria. The operational test states that there must be an affirmative element; in other words, the organization must actually further a “charitable purpose.” The organization must exist exclusively for the charitable purpose, and take no

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179 I.R.C. § 501(c)(3) (laying out requirements for tax exemption):

Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, . . . [and] no part of the net earnings of which inures to the benefit of any private shareholder or individual . . .

180 Id.
181 Rev. Rul. 69-545, 1969-2 C.B. 117 (noting that, to meet the community benefit standard, a hospital must: be governed by a community board, have an emergency room open to the public, have an open medical staff policy, and provide care to all patients who can pay for non-critical services).
182 Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL’Y 302, 312 (2007); *Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501(c)(3)*, IRS (July 13, 2023), https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3 (“In the context of operating a tax-exempt hospital, it’s not enough for a hospital to state that it operates exclusively to promote health. A hospital must also demonstrate that it operates to promote the health of a class of persons that is broad enough to benefit the community. This is known as the community benefit standard.”).
183 *Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501(c)(3)*, supra note 182.
184 Id.
individual profit. A healthcare organization must fulfill other tests as well to achieve tax-exempt status.

This dialogue on the standards of eligibility for nonprofit healthcare organizations to be tax-exempt, namely the emphasis on furthering charitable purpose under the I.R.C. and demonstrating a community benefit, is vital for how it informs the charitable mission statement by which nonprofit healthcare organizations must abide. Significantly, the section 501(c)(3) organizational test also requires charitable assets be devoted to a charitable purpose if an organization is dismantled. As discussed throughout this Comment, this safeguarding of the charitable mission and post-sale charitable assets is frequently compromised.

B. Scrutinizing the Charitable Purpose of Nonprofits

Charitable healthcare organizations have become permanent fixtures of modern society after achieving tax-exempt status. However, the importance of charitable purpose is often downplayed and misunderstood. This oversight poses a challenge for bankruptcy courts when trying to incorporate a nonprofit healthcare business’s charitable purpose effectively in bankruptcy proceedings.

1. The Importance of the Charitable Mission

Given that philanthropic organizations such as nonprofit hospitals are supported financially by generous charitable trusts and endowment funds donated by the public, and that nonprofit organizations exist to provide beneficial services to the community, there is no doubt the public has a significant stake in the use of assets to support the charitable mission. If a nonprofit organization files for bankruptcy, courts naturally examine whether

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185 See id.
186 In addition to fulfilling standard criteria for tax-exemption under I.R.C. § 501(c)(3) and Revenue Ruling 69-545, nonprofit hospitals must adhere to four extra requirements outlined in I.R.C. § 501(r).
187 Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501(c)(3), supra note 182. The IRS website states, “[t]he organizational documents must also permanently dedicate the organization’s assets to charitable purposes upon dissolution.”
188 See supra Part II.B; see also infra Part III.B.2.
assets will be shielded from the claims of creditors and survive bankruptcy.\textsuperscript{190} How charitable assets are handled is relevant in both chapter 7 and 11 bankruptcies.\textsuperscript{191}

Certainly, nonprofit healthcare organizations must prioritize their charitable mission statements when undergoing the bankruptcy process.\textsuperscript{192} This suggests that nonprofit healthcare organizations cannot necessarily move forward with a buyer who submits the best and highest offer, if the best and highest offer contradicts the charitable purpose by which the healthcare organization must abide.\textsuperscript{193} This, of course, is inherently at odds with the principles of the bankruptcy system.

Historically, various courts have demonstrated a deep respect for the charitable purpose of nonprofit hospitals.\textsuperscript{194} The Manhattan Eye, Ear and Throat Hospital ("MEETH") case supports a stronger role for the New York state attorney general over the decision-making of a nonprofit organization’s board.\textsuperscript{195} MEETH, a nonprofit hospital facing declining revenue, sought the approval of the Supreme Court of New York County in a transaction that would lead to the sale of real estate assets and the closure of the hospital.\textsuperscript{196} The Supreme Court of New York County determined that the prospective hospital sale would constitute a fundamental change to the purpose of the charitable


\textsuperscript{191} Richard L. Fox et al., \textit{Shield Donations from Bankrupt Charity’s Creditors}, 43 EST. PLAN. J. 18, 19 (2016) ("This issue is not only relevant when a charity emerges from bankruptcy in a Chapter 11 reorganization and continues its operations, but also when a charity is forced to cease operations and close down its doors in a Chapter 7 liquidation.").

\textsuperscript{192} Cf. Carly Elliott, \textit{The Charity Care Crisis—Where Does the Money Go?: A Sample of Elements To Consider When Evaluating a Program}, \textit{8 J. HEALTH CARE COMPLIANCE}, Sept.–Oct. 2006, at 11, 13. Hospitals all have charitable mission statements to provide care. Given that this mission statement is not allowed to abate during dissolution, it stands to reason that the charitable mission must also be prioritized during bankruptcy.

\textsuperscript{193} See Brody, supra note 190, at 472 ("The bankruptcy of a charity represents the clash of two policy regimes: charity law’s willingness to preserve assets for the public purpose determined by the donor as against bankruptcy law’s desire to maximize assets for distribution to creditors.").

\textsuperscript{194} See, e.g., Manhattan Eye, Ear & Throat Hosp. v. Spitzer, 715 N.Y.S.2d 575, 593 (Sup. Ct. 1999); \textit{In re United Healthcare Sys., Inc.}, No. 97-1159 (NHP), 1997 WL 176574 (D.N.J. Mar. 26, 1997) (reversing the bankruptcy court’s decision to put the interest of creditors above the interest of the public); \textit{but see, e.g.}, Hunter v. St. Vincent Med. Ctr. \textit{(In re Parkview Hosp.)}, 211 B.R. 619 (Bankr. N.D. Ohio 1997) (suggesting that property donated to a nonprofit organization is not limited to uses that further the organization’s charitable mission; rather, the charitable use restriction is a suggestion only).

\textsuperscript{195} See Spitzer, 715 N.Y.S.2d 575.

\textsuperscript{196} \textit{Id.} at 577–78.
organization,197 and concluded that the state attorney general had a responsibility to assess the transaction.198

Upon review, the court concluded that the sale should be prohibited because there was no “reasoned determination” on why the hospital should discontinue operations, which would counteract its charitable mission.199 Through this holding, the MEETH case reinforces the sentiment that a nonprofit organization’s charitable mission should be afforded strong consideration. It did not, however, provide clarity on the relative weight given to the nonprofit’s charitable mission and the interests of the creditors.

The district court in In re United Healthcare System, Inc. also offered support to the charitable mission of nonprofit hospitals.200 In this case, United Healthcare System considered the sale of one of the hospital’s centers due to extreme financial difficulty. After selecting St. Barnabas Healthcare System as the winning bidder, the hospital board sought the bankruptcy court’s approval of the sale. The bankruptcy court invalidated the sale’s terms, faulting the hospital board for lacking “sound business judgment”201 because it failed “to obtain a fair price for the debtor’s assets for the benefit of the creditors of [the] estate.”202 However, the district court disagreed.203

While the bankruptcy court put the interests of the creditors first, the District Court of New Jersey reversed the holding and concluded the bankruptcy court “failed to examine the totality of the circumstances” and did not consider competing public needs as to what was reasonable and appropriate.204 The district court emphasized the importance of charitable purpose, stating “[t]he officers and directors of a nonprofit organization are charged with the fiduciary obligation to act in furtherance of the organization’s charitable mission. In addition, the law allows the bankruptcy court to entertain higher and better offers, which means that the bankruptcy court may not focus solely on price.”205

197 Id. at 595.
198 Id. at 587 (“Since as a . . . charitable[] corporation, MEETH does not have shareholders, the [state] Attorney General, acting as parens patriae, is statutorily involved whenever such a charity seeks to dispose of all, or substantially all, of its assets, as MEETH resolved to do . . . .”).
199 Id. at 597 (noting that the transaction’s terms were not fair and reasonable).
201 Id. at *1 (citing In re United Healthcare Sys., Inc., No. 97–21785(WFT), 1997 Bankr. LEXIS 2358, at *15 (Bankr. D.N.J. Mar. 5, 1997)).
204 See id. at *6.
205 Id. at *5.
This case underscores the importance of respecting the decisions made by a nonprofit organization’s board and officers as they navigate the delicate balance between maximizing value for creditors and fulfilling charitable purpose. However, this case also demonstrates the competing interests courts must weigh when adjudicating on such matters.

The MEETH and United cases represent a few examples of the competing interests that are ill-addressed in nonprofit health care business bankruptcies. As is discussed next, the influence of charitable purpose in nonprofit healthcare bankruptcy proceedings remains unclear, even more than two decades later.

2. Bankruptcy Courts Do Not Know How To Weigh Charitable Purpose

While the aforementioned cases preceded BAPCPA, a recent 2016 decision illustrates that conflicts between nonprofit healthcare debtors and bankruptcy law remain unresolved. In In re HHH Choices Health Plan LLC, a debtor healthcare organization filed for bankruptcy due to financial difficulties, which prompted the need for a sale of assets. The debtor and the committee of creditors had different views on which bidder the assets should be sold to, so the sale required the bankruptcy court’s approval. Of the two bidders, one was favored by the debtor and would have promoted the debtor healthcare organization’s charitable purpose, while the other was favored by creditors for maximizing the sale’s value. Nevertheless, neither sale would have fully repaid the creditors.

The bankruptcy court first discussed the legal standards that applied to the issue, pinpointing that a conflict existed regarding which law should be applied. The court asserted that, although section 363(d)(1) of the Code mandated that applicable non-bankruptcy New York state law should apply, the bankruptcy court maintained “exclusive jurisdiction over the estate and the

206 See In re HHH Choices Health Plan, LLC, 554 B.R. 697 (Bankr. S.D.N.Y. 2016). For a discussion of other recent cases that highlight conflict between bankruptcy and nonprofit law see also supra Part III.B.1. 
207 HHH Choices, 554 B.R. at 698. 
208 Id. at 699.  
209 Id. at 699–702. 
210 Id. at 699. 
211 Id. at 700 (“In the case of an insolvent not-for-profit corporation, section 511 of the New York Not-For-Profit Corporation Law ordinarily, would require the approval of the New York State Supreme Court for a transfer of assets. But clearly, the amendments to the Bankruptcy Code do not mean that that [sic] state court approval is still required because section 1221(e) of the BAPCPA explicitly says otherwise; it says I cannot interpret those provisions of the amended statute to require the approval of any other court for the transfer of property.”).
disposition of its assets.” The bankruptcy court then identified the “much harder question” of which standard under New York law applied, declaring “there is little or no guidance as to how to apply these standards if there are competing proposals that contemplate different outcomes, or if the competing factors point in different directions.”

The bankruptcy court judge explored the differences between the two competing bidders and identified a critical issue that arose when there was not a clear binary choice between a nonprofit’s charitable mission and a higher sale price. He asked: “What relative weight am I to give to the interests of creditors and to the mission of the not-for-profit corporation where those considerations, at least potentially, are in conflict?” After deliberation, the judge approved the bidder favored by the debtors, because it was “more consistent with the mission” of the organization. The bankruptcy court commented that there was a lack of clear guidance in the state law, and that “reasonable people could differ” in their own assessment of which proposal between the two bidders was ultimately picked.

The HHH opinion brilliantly illuminates the challenge and frustration experienced by bankruptcy courts when deliberating nonprofit healthcare debtors’ asset sales: The Code and state nonprofit law often conflict. Further, bankruptcy courts are frequently required to review and apply state law alongside the Code. The law fails to clarify how the competing interests of creditors, debtors, the charitable organization’s board, or the organization’s charitable mission should be weighed, resulting in a frustrating endeavor for bankruptcy courts.

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212 Id. at 700–01.
213 Id. at 701.
214 Id. at 700–01. After comparing the two different bidders, the court agonized about the fundamental predicament in this case, and others like it:

The problem with these cases is that it is quite easy to say that the mission of a not-for-profit corporation should predominate over a higher price if there is no creditor issue. Not-for-profits have no shareholders for whom they are supposed to maximize value. The shareholders whose interests they ordinarily would serve are replaced by the beneficiaries of the charitable mission. So, if creditors are paid, it is easy to say that the mission then takes priority in deciding what to do. But this is not a case where creditors will be paid in full.

Id. at 701–02.
215 Id.
216 Id. at 713.
217 Id. at 704.
218 Id. at 713.
IV. PROPOSED SOLUTIONS

Experts contend “that healthcare institutions . . . are . . . bankruptcy misfits” because the “goals and purposes of a healthcare institution’s bankruptcy do not mesh well with the Bankruptcy Code’s [] existing statutory framework.” The utility of bankruptcy for healthcare organizations that are in financial distress has been extensively deliberated. While this Comment does not claim that the bankruptcy system is a completely ineffective tool in addressing distressed healthcare organizations, it contends that the Code has had limited success in addressing nonprofit health care business bankruptcies. Amendments to the Code are needed.

Numerous critical questions remain unresolved due to the Code’s lack of clarity. Neglecting to address these questions perpetuates a disservice to nonprofit health care businesses and the public as a whole. Part IV.A offers a brief summary of the legal concerns highlighted in this Comment, while Part IV.B suggests bold amendments to the Code are needed to ensure the continuity and sanctity of essential health care services.

A. Recap of Issues

This Comment has identified several issues central to the intersection of bankruptcy and healthcare law. First, bankruptcy courts have inconsistently applied the recoupment doctrine, which can leave uncertain the fundamental debtor protection of the automatic stay for financially-distressed health care businesses. Second, the scope of the state attorney general’s role, while theoretically expanded, remains unclear in practice. Third, bankruptcy courts do not know how to appropriately weigh the charitable mission of a nonprofit health care business in bankruptcy proceedings. Finally, who ultimately

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219 Coordes, supra note 33, at 423.
221 See, e.g., In re United Healthcare Sys., Inc., No. 97-1159 (NHP), 1997 WL 176574, at *10 (D.N.J. Mar. 26, 1997) (commenting that the bankruptcy court’s holding “raised more questions then [sic] it resolved[d], with a strong possibility of both public health and the creditors suffering.”).
222 See supra Part I.C.2 for an extended discussion regarding the debate of recoupment versus setoff in bankruptcy cases.
223 See supra Part II.B for an extended discussion regarding the role of a state attorney general in nonprofit bankruptcies.
224 See supra Part III.B.2 for an extended discussion regarding the weighing of charitable mission in bankruptcy proceedings.
supervises charitable assets and reinforces the charitable mission remains shrouded in uncertainty.225

B. Rethinking Healthcare Business Debtors

As health care business bankruptcies continue to rise,226 the time is ripe to address these issues through the legislative process.227 Amendments to the Code are required to address the needs of the public and the industry.

This Comment proposes a substantial modification—the Code must be amended to establish a provision tailored to nonprofit health care businesses. This provision should encompass, at minimum, the following recommendations:

(1) precise directives outlining the role of the state attorney general;
(2) a detailed list of factors for courts to consider in nonprofit healthcare bankruptcies;
(3) explicit guidelines concerning the extensive and diverse types of transactions that occur in health care business settings; and
(4) a definition for “essential services.”

Recommendation (1) aims to pinpoint the scope of the authority vested in state attorneys general concerning the sales of nonprofit health care businesses. It seeks to clarify whether a state attorney general’s authority applies universally or under specific conditions only. This recommendation would address whether a state attorney general’s authority is triggered by the existence of charitable assets or by the existence of nonprofit debtors. Additionally, this proposal could clarify whether charitable assets require continual oversight, oversight for a predetermined duration of time, or no oversight at all after a sale. Recommendation (1) specifically addresses the debates raised in cases like Verity228 and Gardens,229 exploring the circumstances that require a state attorney general’s supervision of asset sales, and whether a state attorney general is responsible to the charitable assets or to the controlling entity only.

225 See supra Part III.B.1 for an extended discussion of charitable purpose.
226 See supra Part I.C.
227 See generally Matthew B. Lawrence, Medicare “Bankruptcy”, 63 B.C. L. Rev. 1657, 1722 (2022) (arguing that legislation is preferable to regulation because it reduces the possibility of change and likelihood of legal challenge).
228 In re Verity Health Sys. Cal., Inc., 598 B.R. 283 (Bankr. C.D. Cal. 2018); see supra notes 150–62 and accompanying text.
229 Gardens Reg’l Hosp. & Med. Ctr. Liquidating Tr. v. California (In re Gardens Reg’l Hosp. & Med. Ctr., Inc.), 975 F.3d 926 (9th Cir. 2020); see supra notes 92–103 and accompanying text.
Recommendation (2) works to guide courts when they are reconciling the competing interests of charitable healthcare organizations and bankruptcy law. By outlining the specific factors courts should consider and their relative importance, this suggestion would target the complexities identified in *HHH*. and enhance the court’s ability to balance the interests of creditors and the missions of nonprofit healthcare organizations. Further, establishing parameters for evaluating and handling charitable assets would better ensure that nonprofit healthcare organizations fulfill their charitable missions and serve the public effectively. Creating guidelines about which factors courts should prioritize would not only ease the work of courts, but also generate greater predictability and consistency in outcomes.

Recommendation (3) recognizes the range of complex transactions that occur in healthcare business settings and distinguishes those falling under the principles of recoupment and setoff. By offering a more precise delineation of the recoupment doctrine, this recommendation would address the dispute identified in *Gardens* regarding the application of recoupment or setoff in transactions. In turn, debtors would gain clarity ahead of bankruptcy proceedings about their eligibility for automatic stay protection and their prospects for financial stability after filing for bankruptcy.

Lastly, Recommendation (4) proposes establishing a definition for “essential services.” While this suggestion may not directly address the legal issues raised in this Comment, it acts to cement the standing of vital healthcare services as public necessities. Surprisingly, the current Code does not define “essential services,” nor does it provide a definition for “essential service providers.”

Courts have addressed this issue even in the absence of a statutory definition. In those instances, “essential services” typically refer to those services that are necessary for the maintenance of public health and safety, such as emergency medical care and utility services. These services can be protected from

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230 *In re HHH Choices Health Plan, LLC*, 554 B.R. 697 (Bankr. S.D.N.Y. 2016); see supra notes 206–218 and accompanying text.

231 *Gardens Reg’l Hosp.*, 975 F.3d 926; see supra notes 92–103 and accompanying text.

232 *Cf.* Ashley M. McDow & Michael T. Delaney, *Critical Vendors—Necessity or Nullity*, 33 CAL. BANKR. J. 25, 27 (2014) (showing that the Code does define “critical vendors” in the chapter 11 context; something along those lines could be used to define “essential services” for purposes of not-for-profit healthcare bankruptcy).

interruption or discontinuation during the bankruptcy process to ensure that a community’s basic needs are met. The definition of “essential services” can vary depending on the jurisdiction and specific bankruptcy case—especially because no standardized definition is available that can be consistently applied by bankruptcy courts. In addition, “essential services” are only discussed in the context of chapter 9 bankruptcies, which are rare and only apply to municipalities. Recommendation (4) would extend the concept of “essential services” mentioned in chapter 9 of the Code to apply universally to nonprofit healthcare debtors, regardless of the chapter under which the debtor files. Further, it is imperative to amend the Code to provide a clear definition for “essential services” that includes “non-elective critical health care services” in its scope.

This definition would emphasize that specific healthcare services, such as those that aim to save a life or manage serious disease, are nonnegotiable public necessities that cannot be overlooked or relinquished in nonprofit health care business bankruptcies. Creating stringent parameters that limit the scenarios in which discontinuation of “essential services,” especially for nonprofit health care businesses, is permitted, would be invaluable.

The Code should be amended to supply a provision that caters especially to nonprofit health care businesses and responds to competing interests. These recommendations would provide health care businesses a more streamlined and reliable bankruptcy process, reduce the uncertainty surrounding the outcome, and safeguard non-elective critical health care services for communities most in need.

234 See generally Sgarlata Chung, supra note 233, at 54 (articulating the importance of not interrupting essential municipal health and safety services); Kupetz, supra note 232, at 290 (mentioning the importance of maintaining crucial infrastructure in the chapter 9 context; things like “police protection, fire protection, sewage and garbage removal, and schools.”).

235 See Kupetz, supra note 232, at 290–91 (“There is no bright line test for courts to apply when resolving disputes over what governmental services and programs are essential. Those involving public safety, health, and welfare are likely to be viewed as essential. . . . More particularly, programs and services of a local governmental entity that are likely to be deemed essential include . . . programs and services necessary to maintain quality of life in the municipality may be deemed essential if the negative impact of eliminating or reducing such programs and services can be demonstrated and is significant.”).

236 See supra notes 233–35.

237 See Sgarlata Chung, supra note 233, at 54; Kupetz, supra note 232, at 290.

238 See generally Municipal Bankruptcy: A Primer on Chapter 9, NUVEEN (Oct. 5, 2023), https://www.nuveen.com/en-us/insights/municipal-bond-investing/municipal-bankruptcy-a-primer-on-chapter-9 (noting that there are typically over 5,000 commercial chapter 11 filings annually, while there was only one chapter 9 filing as of October 2023).
CONCLUSION

This Comment underscores critical public interests at stake by examining the deficiencies of bankruptcy law in tackling nonprofit health care business bankruptcies. Addressing these issues is particularly critical in rural America, where hospitals are hemorrhaging money and are unable to stay afloat. Certain healthcare facilities are in the category of “situational monopolies” that are “too-important-to-fail,”239 and the United States must deeply contemplate the role of the bankruptcy system in safeguarding those that are critical to vulnerable communities.

In particular, the issue of pediatric wards and children’s units closing in hospitals is a harbinger of how severely the healthcare industry in the U.S. will continue to degrade. It speaks volumes that healthcare organizations routinely decline health care services to pediatric populations as a cost-cutting measure.240 It cannot continue.

Many factors contribute to the financial difficulties of health care businesses, and have led to an increasing number of distressed healthcare organizations to use bankruptcy as a vehicle for achieving financial stability. Healthcare organizations are complex and bankruptcy law must advance to address these complexities.

It has been nearly two decades since BAPCPA was passed in 2005. During this time, it has become evident that the BAPCPA amendments to the Code are inadequate to meet the needs of either healthcare or nonprofit organizations. While one can argue that BAPCPA’s section 333 patient care ombudsman provision should suffice in representing public interests, the inherent limitations of this provision are apparent: The state attorney general is undoubtedly better positioned to represent public interests than a patient care ombudsman, and the creation of the patient care ombudsman role indicates legislative intent in better representing the public’s needs.

Given that nonprofit health care businesses provide indispensable health care services to the public, the Code needs revision to support nonprofit healthcare

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debtors. This Comment proposes the formation of a nonprofit health care business debtor provision as a meaningful step toward addressing the complexities unique to healthcare organizations. Incorporating a precise definition of “essential services” that encompasses non-elective critical health care provides a mechanism to safeguard communities heavily reliant on limited healthcare providers and depleted resources. By ensuring standardization and consistency in bankruptcy proceedings for nonprofit health care businesses, the provision would serve as a signal of stability amidst a tumultuous healthcare landscape exacerbated by disparate state law.

At its core, this Comment sheds light on the struggles of vulnerable communities in receiving vital healthcare services. When we advocate for revisions to the Bankruptcy Code, we endeavor to rewrite this narrative, ensuring access to essential health services and fostering well-being in communities across the nation.

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