

Death, Bankruptcy, and the Public Hospital

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Even before the pandemic, the 90,000 local governments in the United States faced grim fiscal positions. During the pandemic, revenues cratered, costs increased, and many local governments teetered on the brink. Yet few of them considered filing for bankruptcy, though Chapter 9 of the Bankruptcy Code is designed for local governments.

The choice to eschew bankruptcy owes, in part, to scholars of Chapter 9, who conclude that it offers little for political subdivisions, like Detroit. But most local governments are not political subdivisions. They are government-owned businesses, like public hospitals, toll roads, and utility districts.

This Article expands the purview of bankruptcy scholarship to those government businesses, assessing how Chapter 9 operates for them. It does so by taking public hospitals as a case study, offering a comprehensive look at every public-hospital bankruptcy between 1988 and 2021.

What those bankruptcies reveal has implications for government bankruptcy and policy. For government bankruptcy, these public hospitals show that there are in fact two Chapter 9s. The one for political subdivisions may be dysfunctional, as scholars suggest, because bankruptcy cannot solve political problems. But the one for government businesses works effectively and, for hospitals, almost amiably. It helps communities maintain their hospitals and ensures that creditors receive what the Code demands, all without the rancor and creditor foot-dragging that dooms city and county bankruptcies.

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The upshot, which policymakers should heed, is that bankruptcy can save some public hospitals that would otherwise close. That result should prod states toward authorizing such bankruptcies and in turn helping communities save their hospitals.

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Introduction

Every year, millions of patients come to public hospitals for their care.¹ These government-owned hospitals fill a gap, providing care to those who would not receive it for economic, geographic, or discriminatory reasons.

Take Nashville General Hospital. It is a public hospital, serving those who cannot afford care at for-profit or nonprofit hospitals in the Nashville metropolitan area.² The hospital was formed in 1890 because other Nashville hospitals discriminated against Black residents, limiting training opportunities for Black doctors and care opportunities for Black patients.³ To this day, the hospital is viewed as a hospital for the Black community, where residents receive care otherwise out of reach.⁴ And to this day, state and local funding decisions put the hospital on financially shaky footing.⁵

Other public hospitals serve rural areas. There, the public hospital is often the only hospital in its county, and geography and cost prevent residents from otherwise accessing care.⁶

1. See *Fast Facts*, CAL. ASS'N OF PUB. HOSPS. & HEALTH SYS., <https://caph.org/memberdirectory/facts> [<https://perma.cc/FE3D-QNM9>] (noting that California's public healthcare systems "[p]rovide over 10 million outpatient visits each year").

2. Vida Laudarji, Myrna Pierre, Gabriella Heslop, Benjamin Lee, Candace Thompson, Mariah Williams & A. Dexter Samuels, *An Analysis of Nashville's Safety-Net Hospital*, 31 J. HEALTH CARE FOR POOR & UNDERSERVED 1536, 1536-37 (2020).

3. *Id.* at 1537-38. Other minority populations served by safety-net hospitals include Latinos and noncitizens, especially in the Southwest. For noncitizens, the law does not require hospitals to provide treatment, even in the case of emergencies. This has led to nightmarish scenarios with individual hospitals deciding if they have the funding to provide such treatment. See Angela Epolito, *Emergency? How the Federal Focus on Emergency Care Shifts the Cost of Immigrant Healthcare to Public Hospitals*, 17 ANNALS HEALTH L. 323, 323-24 (2008) (discussing a talk by a hospital executive on the inability to provide care to noncitizens).

4. Laudarji et al., *supra* note 2, at 1537. For other examples of metropolitan public hospitals founded due to segregation, see Daniel R. Berg, *A History of Health Care for the Indigent in St. Louis: 1904-2001*, 48 ST. LOUIS U. L.J. 191, 192 (2003); and David Goldberg, Janice L. Benson, Gordon Schiff & Tanu Pandey, *Contributions of Public Hospitals to Regional Health Care: A Population-Based Analysis of the County Health Care System Serving Metropolitan Chicago*, 22 J. HEALTH CARE FOR POOR & UNDERSERVED 346, 346-47 (2011) (noting that public-hospital patients are "predominantly minorities" with "medical vulnerabilities stem[ming] from the interplay of poverty, lack of insurance and under-insurance, communication barriers" and transportation and resource limitations).

5. Laudarji et al., *supra* note 2, at 1540-42 (noting that Medicaid nonexpansion and Nashville's budgeting have resulted in financial troubles for the hospital).

6. See Jack Needleman & Michelle Ko, *The Declining Public Hospital Sector*, in THE HEALTH CARE SAFETY NET IN A POST-REFORM WORLD 200, 202-03 (Mark A. Hall & Sara Rosenbaum eds., 2012) (noting that public hospitals are 72% nonurban); Mary H. Rose & Rebecca J. Winthrop, *So Many Troubled California Health Care Districts, So Many Have Filed Chapter 9—Lessons to Be Learned*, 35 CAL. BANKR. J. 189, 190 (2020) (noting that 54 of California's 79 hospital districts are in rural areas); *Twenty-Five Things to Know About Texas Rural Hospitals*, TEX. ORG. RURAL & CMTY. HOSPS. (Dec. 2018), <https://capitol.texas.gov/tlodocs/86R/handouts/C2102019030709001/3c44afae-f94a-4d71-900f-289dc31f9e94.PDF> [<https://perma.cc/7XSQ-USGE>].

Nor are these public hospitals mere stopgaps in our healthcare system. In urban areas, public hospitals provide one-fifth of all emergency care and one-third of all outpatient visits; in rural areas, two-fifths of all hospitals are public hospitals.⁷ And by default, it is these public hospitals that provide healthcare to the indigent.⁸

So, unsurprisingly, when public hospitals close, public health suffers. One study, published in the *Journal of the American Medical Association*, compared patients in Shasta County, whose public hospital closed, with patients in San Luis Obispo County, whose public hospital stayed open.⁹ The results were stark: One year after the closure, Shasta County saw a 13.7 percentage-point increase in patients without a regular provider and a 6.1 percentage-point increase in patients denied care—numbers that, in contrast, remained stagnant or declined in San Luis Obispo County.¹⁰ For rural public hospitals, the results are worse, closures being associated with an 8.7% increase in inpatient mortality.¹¹

And for the past few decades, public hospitals across the United States have been closing left and right. In 1983, there were 1,691 public hospitals;¹² by 2021, there were 923.¹³ Of that decline, some is attributable to conversions, which preserve the hospital in private form. But one-fourth of urban public hospitals and one-sixth of nonurban ones closed completely.¹⁴ Many were the sole hospital in a county, leaving residents without ready access to care.¹⁵

Today, the financial pressures remain enormous, putting public hospitals on “life support,” as costs rise for everything from equipment to

7. Needleman & Ko, *supra* note 6, at 200.

8. See Thomas G. Rundall & Wendy K. Lambert, *The Private Management of Public Hospitals*, 19 HEALTH SERVS. RSCH. 519, 524-25 (1984); Keren H. Deal, Judith A. Kamnikar & Edward G. Kamnikar, *Challenges and Opportunities Facing Public Hospitals*, 63 J. GOV'T FIN. MGMT. 12, 13 (2014).

9. Andrew B. Bindman, Dennis Keane & Nicole Lurie, *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 J. AM. MED. ASS'N 2899, 2899 (1990).

10. *Id.* at 2902. The percentage of patients who lacked a regular care provider nearly doubled—from 14% to 27.7%—and the percentage of patients who were denied care increased from 10.8% to 16.9%.

11. Kritee Gujral & Anirban Basu, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality* 10 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26182, 2019).

12. Needleman & Ko, *supra* note 6, at 201.

13. *Fast Facts on U.S. Hospitals, 2024*, AM. HOSP. ASS'N, <https://www.aha.org/infographics/2024-01-18-fast-facts-us-hospitals-infographics> [<https://perma.cc/GCY6-6P25>]. As a percentage, public hospitals have declined from one-fourth of all hospitals (in 1999) to one-fifth of all hospitals (in 2010). Laurie E. Felland & Lucy Stark, *Local Public Hospitals: Changing with the Times*, CTR. FOR STUDYING HEALTH SYS. CHANGE 2 (Nov. 2012), <http://www.hschange.org/CONTENT/1326/1326.pdf> [<https://perma.cc/SCGG-E3Y5>].

14. Needleman & Ko, *supra* note 6, at 204, 209.

15. *Id.* at 209 (noting that 39% of rural hospitals that closed were the only hospital in their county).

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personnel to debt service.¹⁶ And profit margins are razor thin. The *average* public hospital only breaks even.¹⁷ One in three loses money and is unsustainable in its current form.¹⁸

For public hospitals experiencing financial distress, there are a few options. They can close, as many have. They can privatize, as some do. Or they can file for bankruptcy.

There has, however, been little academic discussion of bankruptcy as an option for public hospitals.¹⁹ Because public hospitals are government-run businesses, they file under Chapter 9 of the Bankruptcy Code (designed for government entities), not Chapter 11 (designed for private businesses). So they are not captured by scholarship on Chapter 11. And scholars of government bankruptcy focus on a few headline bankruptcies—Bridgeport, Detroit, Stockton, Jefferson County, and Orange County—all of which are political subdivisions of states, not businesses.²⁰

And what scholars have discovered in Chapter 9 hardly recommends it for public hospitals or other government businesses. In their foundational work on Chapter 9, Michael McConnell and Randal Picker write that “municipal bankruptcy law does not well serve its intended purposes.”²¹ Omer Kimhi calls Chapter 9 “a solution in search of a problem.”²² Laura Coordes argues that Chapter 9 is “a failure of bankruptcy law”²³

16. William A. Morehead, Joshua R. Zender & Keren Deal, *Public Hospitals: Are They on Life Support?*, 68 J. GOV'T FIN. MGMT. 46, 47 (2019).

17. Felland & Stark, *supra* note 13, at 1-2.

18. Samuel R. Maizel & Craig Garner, *The Poor Get Poorer: The Fate of Distressed Hospitals Under the Affordable Care Act*, NORTON BANKR. L. ADVISER, Dec. 2012, at 1 (noting that over one-third of all hospitals lost money in 2012). For rural hospitals, the number is on par, even slightly worse: just over 35% had a negative margin in 2019. George H. Pink & G. Mark Holmes, *Rural Hospital Closures and an Overview of the Rural Emergency Hospital*, NC RURAL HEALTH RSCH. PROGRAM 12 (Feb. 18, 2022), <https://webservices.ncleg.gov/ViewDocSiteFile/29904> [<https://perma.cc/4AJB-3RGZ>]; Nancy M. Kane, Sara J. Singer, Jonathan R. Clark, Kristof Eeckloo & Melissa Valentine, *Strained Local and State Government Finances Among Current Realities that Threaten Public Hospitals' Profitability*, 31 HEALTH AFFS. 1680, 1680 (2012) (noting the financial challenges facing public hospitals and the higher profitability of private hospitals).

19. To date, the most extensive treatment is Diane Lourdes Dick, *Public Hospital Bankruptcies and an Evolving Functional Interpretation of the Bankruptcy Code*, BANKR. L. LETTER, Aug. 2019, at 1, 1-12.

20. See, e.g., Melissa B. Jacoby, *Federalism Form and Function in the Detroit Bankruptcy*, 33 YALE J. ON REGUL. 55 (2016); Frederick Tung, *After Orange County: Reforming California Municipal Bankruptcy Law*, 53 HASTINGS L.J. 885 (2002); Dorothy A. Brown, *Fiscal Distress and Politics: The Bankruptcy Filing of Bridgeport as a Case Study in Reclaiming Local Sovereignty*, 11 BANKR. DEVS. J. 625 (1995).

21. Michael W. McConnell & Randal C. Picker, *When Cities Go Broke: A Conceptual Introduction to Municipal Bankruptcy*, 60 U. CHI. L. REV. 425, 426 (1993).

22. Omer Kimhi, *Chapter 9 of the Bankruptcy Code: A Solution in Search of a Problem*, 27 YALE J. ON REGUL. 351, 351 (2010).

23. Laura Napoli Coordes, *Restructuring Municipal Bankruptcy*, 2016 UTAH L. REV. 307, 342.

that “undermines the very objectives it is designed to help municipalities accomplish.”²⁴ Vince Buccola describes Chapter 9 as “a marked failure.”²⁵

Even the rosier appraisers of Chapter 9 recognize its shortfalls. Juliet Moringiello, for instance, writes that Chapter 9 “may only be as effective as the state governance that accompanies it,” noting that the chapter could, at best, be part of the solution for distressed municipalities.²⁶ David Skeel and Clayton Gillette hold out more hope, urging bankruptcy judges to strong-arm municipalities into governance reform.²⁷ Though even they note the bankruptcy courts’ historical unwillingness to do so and potential legal pitfalls.²⁸

But, as this Article reveals, the failings of Chapter 9 for political subdivisions do not hold for public hospitals, and likely do not hold for government businesses more broadly. On the contrary, bankruptcy has much to offer the public hospital and other government businesses.

This Article shows as much by offering a comprehensive view of public-hospital bankruptcy. It uses a hand-collected data set comprising filings of every public-hospital bankruptcy from 1988 (when Congress added a key provision to Chapter 9)²⁹ to 2021, supplementing those with practitioner interviews, local news reports, and audits to capture the full story of these bankruptcies.

What emerges is a picture of public hospitals as central institutions in their communities and institutions that benefit from bankruptcy. These hospitals are generally medium-sized businesses, often the largest employer in their county. Their creditor lists likewise show a local footprint, listing dozens of local businesses and individuals who are vendors or service providers.

The most common reason for these hospitals’ bankruptcies is a reduction in Medicare or Medicaid reimbursements. That owes to the hospitals’ patient mix: they tend to treat those without private insurance, leading to many poor (Medicaid) and elderly (Medicare) patients. A charitable mission also leads the hospitals to provide a disproportionate

24. *Id.* at 308.

25. Vincent S.J. Buccola, *The Logic and Limits of Municipal Bankruptcy Law*, 86 U. CHI. L. REV. 817, 817 (2019).

26. Juliet M. Moringiello, *Goals and Governance in Municipal Bankruptcy*, 71 WASH. & LEE L. REV. 403, 404 (2014).

27. Clayton P. Gillette & David A. Skeel, Jr., *Governance Reform and the Judicial Role in Municipal Bankruptcy*, 125 YALE L.J. 1150, 1153-54 (2016).

28. *Id.* at 1195, 1202-16 (addressing legal challenges).

29. The provision is the current Section 928, which clarified that secured creditors could maintain a lien on future revenues, giving secured creditors more protection for their interests in bankruptcy. 11 U.S.C. § 928 (2018); see Robert S. Amdursky, *The 1988 Municipal Bankruptcy Amendments: History, Purposes, and Effects*, 22 URB. LAW. 1, 4-7 (1990).

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amount of free care.³⁰ With that business model, congressional or state reductions in funding for those programs lead to a plunge in public hospitals' revenues. In turn, that leads many to file for bankruptcy.

These bankruptcies, though, do not look like the typical business or government bankruptcy. Here, everyone wants to save the hospital, or at least maintain some healthcare in the community. Reflecting that desire, creditors use fewer leverage points to extract value, an otherwise-common tactic in business bankruptcies and political-subdivision bankruptcies. Creditors, for instance, rarely file a motion to dismiss, the ultimate way to ensure bankruptcy cannot curtail their rights. Few creditors raise objections or bring adversary proceedings, two other mechanisms for creditors to upend the process or extract settlement value. And nearly all cases confirm a plan of reorganization.

That plan can take one of two tacks. The more common plan is a true reorganization, in which the hospital cuts unprofitable services, increases funding, undoes bad business decisions, and continues operating as a government business. The more recent trend, though, is privatization, either a full privatization through a sale to a private business or a partial privatization in the form of a management agreement or lease. That gets the hospital into the hands of a larger entity with expertise in managing hospitals and economies of scale that can make ends meet for a hospital when public ownership does not.

Both routes have proven successful for hospitals. Fewer of these public hospitals return to bankruptcy than their private (nonprofit and for-profit) counterparts. Qualitatively, the bankruptcies are sensible: hospitals do not generally file for bankruptcy without any prospect of revival. Indeed, using bankruptcy, the hospitals usually do maintain healthcare in the community.

The case of public hospitals, then, adds much to our understanding of government bankruptcy under Chapter 9. These hospitals do not resemble the bankruptcies of political subdivisions at all, and in fact work well. Communities aim to keep their hospital and they usually do. Within the bankruptcy, there is little strife and creditors do not play hardball to extract every cent.³¹ In short, bankruptcy works for these government businesses even though it does not for political subdivisions.

This contrast between political-subdivision bankruptcy and government-business bankruptcy likely owes to the disaggregation of services.³²

30. See Ron J. Anderson, Paul J. Boumbulian & S. Sue Pickens, *The Role of U.S. Public Hospitals in Urban Health*, 79 ACAD. MED. 1162, 1163-64 (2004) (noting that a subset of urban public hospitals that are 2% of all hospitals provide 25% of uncompensated care).

31. Cf. Jared A. Ellias & Robert J. Stark, *Bankruptcy Hardball*, 108 CALIF. L. REV. 745, 748-51 (2020) (describing hardball tactics in corporate bankruptcy).

32. For other benefits of disaggregating services, see generally Michael A. Francus, *Disaggregating State Bankruptcy*, 171 U. PA. L. REV. 1589 (2023).

A public hospital provides one service. It has an elected board dedicated to the provision of that service and it collects taxes (and healthcare payments) for the purpose of maintaining the hospital. That hospital is visible and tangible for everyone in the community, so the bankruptcy revolves around a sole goal and defined resources for achieving that goal. And if politics *is* a problem, privatizing the hospital can obviate politics by placing control of the hospital in the hands of those immune from election.

This scenario differs from the city or county bankruptcy, where hard tradeoffs must be made across residents. Some benefit from a local park; others do not. Some benefit from pensions; others do not. And so on. The result is that interest groups and politicians hotly contest those tradeoffs, leading to rancor in those bankruptcies. Nor can the city be sold to obviate political problems. In turn, the inability of bankruptcy to rework political structures means that the political problems remain, leading to the same systemic fiscal challenges that led the city into bankruptcy and a likely return to fiscal distress.

Finally, this contrast between the floundering of political-subdivision bankruptcy and the success of public-hospital bankruptcy suggests that policymakers should carefully consider bankruptcy as an option for public hospitals that find themselves facing fiscal crises. That is especially true for states that currently bar their public hospitals from filing for bankruptcy, which should pass legislation authorizing such bankruptcies. Access to bankruptcy may well save public hospitals.

Access to bankruptcy is doubly important because alternatives to bankruptcy do not work for public hospitals. While most failed businesses use state-law alternatives (foreclosure, sale, receivership, and assignment for the benefit of the creditors) to wind up their affairs, public hospitals cannot. Those state-law options offer little to public hospitals because each state-law option relies on the business dissolving, and public hospitals cannot freely dissolve after, say, a receivership. Instead, they would carry forward their unsustainable debt load. The result would be no debt relief and a debt burden that prevents the hospital from getting back on its feet.

That's where bankruptcy comes in. By offering a discharge, bankruptcy enables these hospitals to move beyond their past debts. By allowing free-and-clear sales, bankruptcy enables buyers to avoid successor liability. Together, those benefits make a reorganization or sale easier. Chapter 9 may therefore save some public hospitals that would otherwise close.

The balance of this Article proceeds as follows. Part I details the public-hospital bankruptcy, examining what drives public hospitals into bankruptcy, the business position of public hospitals in bankruptcy, how public hospitals finance their bankruptcies, and what they do to exit

bankruptcy. Part II measures public hospitals against the current literature on government bankruptcy, showing that the hospital cases differ from prior work on political-subdivision bankruptcy and provide a path forward for other government businesses. Part III shows why bankruptcy is uniquely helpful for public hospitals and why states should authorize it instead of limiting public hospitals to state-law alternatives. Part IV concludes.

I. Public Hospital Bankruptcy

Outside of bankruptcy, public hospitals differ from private businesses in their structures and goals. As government-run businesses, the typical “public hospital” is structured as a hospital district (a form of local government) that owns and operates a hospital. (For simplicity, I will use the label “hospital” unless the distinction between the district and the hospital matters.) Thus, the public hospital’s leadership typically stands for election just as a school board or mayor would.³³ And the hospital’s goal is to sustainably provide healthcare to the community. All this differs from private corporations, which are not governmental entities and have a board elected by shareholders who seek to maximize their value.

In bankruptcy, too, public hospitals differ from private hospitals. Government businesses (including public hospitals) file under Chapter 9, while private businesses—even in the same industry—file under Chapter 11. Chapter 11 centers on a plan of reorganization, in which the business corrects past mistakes to become viable going forward and distributes its value to creditors based on the Code’s list of priorities. Chapter 9 is modeled on Chapter 11 and likewise centers on a reorganization plan. But federalism concerns sharply limit the bankruptcy court: states must authorize filing (in contrast, private businesses can file freely),³⁴ and the bankruptcy judge has no authority to restructure a government debtor’s local politics, change the debtor’s policy choices, direct the debtor’s regulatory power, or exercise the debtor’s taxing power.³⁵

This Part looks at how that Chapter 9 regime, and its limitations, cash out in public-hospital bankruptcies.³⁶ To do so, it examines the 55

33. Kane et al., *supra* note 18, at 1680.

34. 11 U.S.C. § 109(c)(2) (2018).

35. *Id.* § 904.

36. While it is hard to be certain that public hospitals in bankruptcy are similar to public hospitals generally in distress, there are some indicators that they are. For one, the causes of public-hospital distress are typically unconnected to the availability of bankruptcy: Medicare reductions affect all states, and population decline isn’t tied to the availability of Chapter 9. Likewise, states that authorize bankruptcy for public hospitals aren’t politically uniform—the leading states are California and Texas. In the same vein, the public hospitals that struggle tend to be rural, and research on rural hospitals suggests that they tend to struggle across the country, unrelated to whether their states authorize Chapter 9. See Clary Estes, *1 in 4 Rural Hospitals Are at Risk of Closure and the Problem is Getting Worse*, FORBES (Feb. 24, 2020), <https://>

public hospital bankruptcies from 1988 to 2021. It draws on data from the dockets in those cases as well as key filings—petitions (available in 48 cases), disclosure statements (available in 41 cases), and reorganization plans (available in 42 cases)—along with ancillary documents like financial statements. I have also supplemented the formal data with news reports and practitioner interviews to fill out a more complete picture of what these bankruptcies look like.

This Part presents those data and that picture of public hospital bankruptcy in four Sections. The first describes the business model of public hospitals and how that business model, in particular its reliance on Medicare and Medicaid, translates into systemic causes of public hospital bankruptcies. The second examines those hospitals in bankruptcy, showing that they tend to be medium-sized businesses with roots in their communities rather than small, economically unimportant businesses or massive, headline bankruptcies of national corporations. The third discusses how public hospitals finance their bankruptcies, showing that they rely primarily on taxation instead of the traditional finance mechanisms of corporate debtors. The final section describes how public hospitals exit bankruptcy, showing that the sale-versus-reorganization decision turns on the viability of the public provision of hospital services and the need for privatization to maintain the service.

A. Causes of Public Hospital Bankruptcy

The causes of public hospital bankruptcies follow logically from their business model. That business model includes an outsized amount of unprofitable care. And the defining feature of each revenue stream is that revenues are outside of the hospital's control.

Start with the largest sources of revenue, Medicare and Medicaid reimbursements. The former are set by the federal government, the latter by state governments. Hospitals cannot turn away those without money to pay for emergency services, so they bear significant costs for uncompensated, or partially compensated, care.³⁷ Private payors (think health-insurance companies) tend to peg their reimbursement rates to Medicare.³⁸ Finally, taxation, an advantage enjoyed by public hospitals but not

www.forbes.com/sites/claryestes/2020/02/24/1-4-rural-hospitals-are-at-risk-of-closure-and-the-problem-is-getting-worse [<https://perma.cc/73PL-ZAT8>].

37. See Epolito, *supra* note 3, at 324.

38. See Eric Lopez & Tricia Neuman, *How Much More than Medicare Do Private Insurers Pay? A Review of the Literature*, KAISER FAM. FOUND. (Apr. 15, 2020), <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature> [<https://perma.cc/NY9L-PZW5>]; Rose & Winthrop, *supra* note 6, at 39 (noting that the link has become a problem with Medicare and Medicaid cuts).

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private ones, is also beyond the hospitals' control. Tax rates are often limited by statute³⁹ or require a vote.⁴⁰

Public hospitals can fail for the diverse, ordinary reasons that other businesses fail. Kennewick Hospital is a good example, where the public hospital lost out to a private competitor whose emergency room was more successful and drew patients away from the public hospital.⁴¹ Likewise, Hardeman County Memorial Hospital found itself in bankruptcy after a few bad business decisions, including the decision to lease an imaging center 300 miles from the hospital, which proved unprofitable.⁴² Jack County Hospital lost an arbitration to an insurer and could not pay.⁴³

But there are some throughlines in public-hospital bankruptcies as well, pointing to larger factors that lead public hospitals to failure. Most prominent among these are reductions in Medicare or Medicaid reimbursements, either by the federal or state governments. Those reductions slash revenues, leading to financial troubles. A secondary factor is population decline, which erodes public hospitals' tax bases and often their customer bases as well. Beyond these two factors, there is little else that systemically accounts for public hospital bankruptcies.

1. Changes in Medicare and Medicaid

The leading systemic cause of public-hospital bankruptcy is a reduction in Medicare and Medicaid reimbursements by state and federal governments. As it stands, Medicare and Medicaid do not cover the cost of providing services, so a hospital loses ten to twenty cents on the dollar for each Medicare or Medicaid patient.⁴⁴ Heavy reliance on Medicare and Medicaid, coupled with cuts to those revenue sources—even cuts that drop the reimbursement only a few cents on the dollar—tip many hospitals into bankruptcy.

Hospitals' reliance on these reimbursements is evident in the filings that list the percentage of the hospitals' budgets that derive from Medicare or Medicaid:

39. *E.g.*, CAL. HEALTH & SAFETY CODE §§ 32202-03 (West 2024).

40. *See infra* note 302 and accompanying text (discussing communities' votes to increase their own taxes to fund public hospitals).

41. Disclosure Statement at 25-27, *In re* Kennewick Pub. Hosp. Dist., No. 17-02025-9 (Bankr. E.D. Wash. May 11, 2018), ECF No. 846.

42. Josiah M. Daniel, III, *Rx for Ailing Rural Public Hospitals: Chapter 9 Bankruptcy and Pro Bono Lawyering*, 18 HOUS. J. HEALTH L. & POL'Y 205, 211 (2018); Disclosure Statement at 15-16, *In re* Hardeman Cnty. Hosp. Dist., No. 13-70103 (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288.

43. Disclosure Statement at 14, *In re* Jack Cnty. Hosp. Dist., No. 20-42012 (Bankr. N.D. Tex. Nov. 23, 2020), ECF No. 61.

44. *See* Rose & Winthrop, *supra* note 6, at 193 n.21 (noting that both Medicare and Medicaid reimburse below 90% of the cost of providing care).

Hospital	Medicare, Medicaid Percentages ⁴⁵	Total (rounded)
Tri-City Mental Health Center	.09% Medicare, 97.5% Medicaid	98%
Pushmataha County Hospital	Not itemized	90%
Sierra Valley Hospital	14% Medicare, 73% Medicaid	87%
West Contra Costa Hospital (2016 filing)	37-38% Medicare, 47-49% Medicaid	84-87%
Chowchilla Memorial Hospital	24.5% Medicare, 56.7% Medicaid	81 %
Iron County Hospital	50% Medicare, 30% Medicaid	80%
Sierra Kings Hospital	Not itemized	74%
Atoka County Hospital	58% Medicare, 16% Medicaid	74%
West Contra Costa Hospital (2006 filing)	47% Medicare, 24% Medicaid	71%
Corcoran Hospital District	35% Medicare, 36% Medicaid	71%
Tulare Hospital	Not itemized	70%
Surprise Valley Hospital	34.2% Medicare, 35.9% Medicaid	70%
Pauls Valley Hospital	Not itemized	67-70%
Union Hospital	51.8% Medicare, 13.7% Medicaid	66%
Southern Inyo Hospital (1999 filing)	48.8% Medicare, 16.7% Medicaid	66%
Palm Drive Hospital (2007 filing)	Not itemized	60%
Watonga Hospital	40% Medicare, 20% Medicaid	60%
Craig County Hospital	44% Medicare, 14% Medicaid	58%
Southern Humboldt Hospital	Not itemized	56%
Mendocino Coast Hospital	27% Medicare, 21% Medicaid	48%
Hardeman County Hospital	23% Medicare, 3% Medicaid	26%

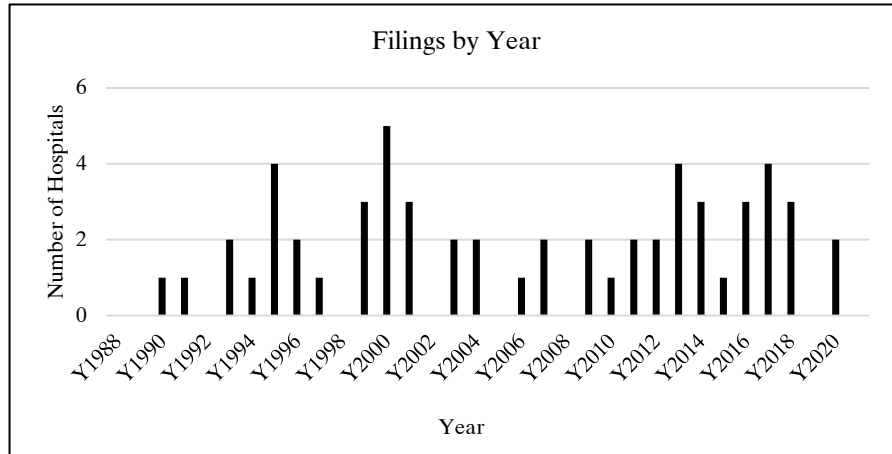
And 19 of the 41 available disclosure statements identify a reduction in reimbursements as a cause of the bankruptcy at issue.⁴⁶

45. App. C (disclosure statements). Disclosure statements do not require reporting information on Medicare or Medicaid reimbursements, so this information is unavailable for some hospitals. Hospitals that do report can also use different categories—for example, percentage of revenues instead of percentage of operating revenues. This is consistent with other work finding that public hospitals generally depend more on Medicaid than private ones. *See, e.g.*, Goldberg et al., *supra* note 4, at 347; Bindman et al., *supra* note 9, at 2899.

46. App. C (Disclosure Statements).

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Figure 1



A chart of bankruptcy cases over time confirms this too.⁴⁷ Years with higher-than-usual bankruptcy filings tend to correspond to reductions in Medicare and Medicaid. The spikes in filings between 1999-2001, 2011-14, and 2016-18 all correspond to such reductions.⁴⁸

Balanced Budget Act. The first spike corresponds to the effects of the 1997 Balanced Budget Act, which imposed what were then the largest-ever cuts to Medicare reimbursements.⁴⁹ The cuts took effect during the 1998-2002 fiscal years, decreasing hospital reimbursements for Medicare by \$115 billion.⁵⁰

47. Between 1988 and 2021 there were 57 hospital petitions filed, reflecting 55 bankruptcies. See App. A (Dockets). (In Kentucky, two different entities are involved in the hospital and thus both Adair County Hospital District and Adair County Public Hospital district filed simultaneously. The Los Medanos filings were likewise two separate legal entities that were involved in operating the same hospital.) This number was reached by conducting a Bloomberg court-docket search, filtering for Chapter 9 cases in the U.S. Bankruptcy Courts between January 1, 1988, and December 31, 2021. That search yielded 277 results. Of those, 35 were either test filings or misfilings by the court. Another nine were individuals who erroneously listed Chapter 9 instead of the appropriate Chapter 7. One healthcare business, Diagnostic Health Services Inc., was a Chapter 11 misfiled as a Chapter 9. In total, then, from 1988 to 2021 there were 231 Chapter 9 petitions, with the 55 public-hospital cases representing one quarter of all government bankruptcies filed.

48. By contrast, the absence of filings during COVID owes to federal pandemic spending. See Pink & Holmes, *supra* note 19, at 13.

49. Robert L. Phillips, Jr., George E. Fryer, Frederick M. Chen, Sarah E. Morgan, Larry A. Green, Ernest Valente & Thomas J. Miyoshi, *The Balanced Budget Act of 1997 and the Financial Health of Teaching Hospitals*, 2 ANNALS FAM. MED. 71, 71 (2004).

50. JENNIFER O'SULLIVAN, CELINDA FRANCO, BETH C. FUCHS, BOB LYKE, RICHARD PRICE & KATHLEEN S. SWENDIMAN, CONG. RSCH. SERV., 97-802, MEDICARE PROVISIONS IN THE BALANCED BUDGET ACT OF 1997, at 7 (1997); cf. Elizabeth J. Austin & Holly G. Gydus, *Alternatives to Bankruptcy for Insolvent Nursing Homes: A Case Study*, 8 AM. BANKR. INST. L.

The hospitals that entered bankruptcy in this stretch noted as much. Alta Hospital, when it filed in 2001, named the Balanced Budget Act as a cause of its failure.⁵¹ So did Chowchilla Memorial Hospital in its 2000 filing.⁵² As did Lower Cameron Parish Hospital in its 1999 filing.⁵³ Other hospitals that filed in this window, like Sierra Valley Hospital in 2000, more elliptically referred to “[m]andatory payment reductions by government.”⁵⁴

Affordable Care Act. The early-2010s filings center on Medicaid nonexpansion. The Affordable Care Act, among other reimbursement changes, cut hospitals’ “disproportionate share” payments, which reimburse the hospital for uncompensated care and partially reimbursed Medicaid care.⁵⁵ That reduction was supposed to be offset by expanding Medicaid, which would reduce uncompensated care. But some states refused the federal Medicaid funding, and the Supreme Court permitted them to do so in *National Federation of Independent Business v. Sebelius*.⁵⁶ The result was higher costs for hospitals in nonexpansion states.

The bankruptcies in this window reflect that. Of the ten cases from 2011 to 2014, three were in South Carolina and one each in Texas, Mississippi, Georgia, Oklahoma, and Kentucky⁵⁷—all nonexpansion states at the time. And these hospitals blamed reimbursement changes. Pauls Valley Hospital, an Oklahoma hospital that filed in 2013, said the Affordable Care Act “put[] immense pressure” on the hospital.⁵⁸ Adair County Hospital, in Kentucky, blamed a “shifting healthcare reimbursement envi-

REV. 95, 95 (2000) (noting that the Balanced Budget Act of 1997 pushed many nursing homes into insolvency).

51. Disclosure Statement at 3, *In re Alta Healthcare Dist.*, No. 01-17857 (Bankr. E.D. Cal. June 2, 2004), ECF No. 406.

52. Disclosure Statement at 2, *In re Chowchilla Mem’l Hosp. Dist.*, No. 00-13597 (Bankr. E.D. Cal. Mar. 30, 2001), ECF No. 49.

53. Disclosure Statement at 5, *In re Lower Cameron Cnty. Hosp. Serv. Dist.*, No. 99-21290 (Bankr. W.D. La. Apr. 19, 2000), ECF No. 32.

54. Disclosure Statement at 3, *In re Sierra Valley Dist. Hosp.*, No. 00-30288 (Bankr. E.D. Cal. June 28, 2002), ECF No. 66.

55. Maizel & Garner, *supra* note 18, at 2.

56. 567 U.S. 519, 585 (2012).

57. There were 11 filings because Kentucky has a structure where two entities are involved in running the hospital. *See* notes to App. A (Dockets).

58. Disclosure Statement at 2-3, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 313. Other Oklahoma hospitals that filed did likewise. *See* Disclosure Statement at 20, *In re Craig Cnty. Hosp. Auth.*, No. 15-10277 (Bankr. N.D. Okla. Oct. 28, 2016), ECF No. 256; Disclosure Statement at 14, *In re Pushmataha Cnty. – City of Antlers Hosp. Auth.*, No. 16-81001 (Bankr. E.D. Okla. Nov. 12, 2019), ECF No. 207 (“Medicare/Medicaid reimbursement margins have fallen significantly in recent years”); Disclosure Statement at 14, 17, *In re Atoka Cnty. Healthcare Auth.*, No. 17-80016 (Bankr. E.D. Okla. Mar. 21, 2022), ECF No. 255 (“Oklahoma was initially hesitant to expand Medicaid, which was particularly harmful to rural hospitals.”).

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ronment.”⁵⁹ Public discussion around these bankruptcies likewise highlighted the role of Medicaid nonexpansion.⁶⁰

Medi-Cal. The string of California bankruptcies in the late 2010s owes in part to California’s redesign of its Medicaid reimbursement system, which took effect in 2014 for most public hospitals.⁶¹ That lowered the reimbursement for California’s Medicaid program, Medi-Cal, with a series of bankruptcies following.⁶²

Of the ten bankruptcies in this stretch, five are California hospitals. And they too blame the reduction in reimbursements.⁶³ Notably, another two between 2016 and 2018—Atoka County Hospital and Pushmataha County Hospital—are Oklahoma bankruptcies that lay blame on the state’s Medicaid nonexpansion.⁶⁴ And Iron County Hospital, a 2018 Missouri bankruptcy, likewise owes to the state’s Medicaid nonexpansion.⁶⁵

To sum up, Medicare and Medicaid reductions are not the sole cause of public hospital bankruptcies, but they play a major role. Ordinary

59. Disclosure Statement at 5, *In re Adair Cnty. Hosp. Dist.*, No. 13-10940 (Bankr. W.D. Ky. Dec. 18, 2015), ECF No. 316.

60. *E.g.*, Andy Miller, *Latest Hospital Closing a Blow to Rural Residents*, GA. HEALTH NEWS (Aug. 26, 2013), <https://www.georgiahealthnews.com/2013/08/latest-hospital-closing-blow-rural-residents> [<https://perma.cc/LW27-6RJG>]; Andy Brack, *Rural S.C. Hospitals Close, More Threatened*, FREETIMES (May 16, 2019), https://www.postandcourier.com/free-times/news/rural-s-c-hospitals-close-more-threatened/article_0d8bbb26-bca0-5e85-90f5-4dc1cde9ac74.html [<https://perma.cc/7SMN-TNJW>]; Editorial, *In Iron County, Rural Health Care Catastrophe Comes Home*, ST. LOUIS POST-DISPATCH (Mar. 8, 2018), https://www.stltoday.com/opinion/editorial/editorial-in-iron-county-the-rural-health-care-catastrophe-comes-home/article_5de78289-8188-5c47-b29e-1f9c4861e0fd.html [<https://perma.cc/D47F-A598>]; Shannon Muchmore, *Vinita’s Craig General Hospital Declares Bankruptcy, the Latest in a String of Rural Hospitals to Do So*, TULSA WORLD (Feb. 3, 2019), https://tulsaworld.com/news/local/vinitas-craig-general-hospital-declares-bankruptcy-the-latest-in-a-string-of-rural-hospitals-to/article_354e4c2a-fd8d-57e6-917f-1c737b020713.html [<https://perma.cc/7JDF-ZTNJ>]; Emily Wavering Corcoran & Sonya Ravindranath Waddell, *Rural Hospital Closures and the Fifth District*, ECON FOCUS, 1st Quarter 2019, at 28, 29 (noting research on closures being higher in nonexpansion states). Other research has found that hospitals (regardless of public or private status) in nonexpansion states were more likely to close than those in expansion states. *See* Richard C. Lindrooth, Marcelo C. Perraiillon, Rose Y. Hardy & Gregory J. Tung, *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFS. 111, 117 (2018).

61. *See* CAL. WELF. & INST. CODE § 14105.28(b) (West 2024).

62. As Mary H. Rose and Rebecca J. Winthrop note, a series of decisions in California compounded this problem, notably a 2% Medicare cut in 2011, Medicare reimbursement reductions for the uninsured in 2012, and budget sequestration in 2013. *See* Rose & Winthrop, *supra* note 6, at 193-95. The effect of all these seems not to have hit immediately, a lag similar to some of the nonexpansion bankruptcies. Practitioners have also mentioned that earthquake standards in California have contributed to hospitals’ fiscal problems by imposing further costs (retrofitting) without providing hospitals money to cover those costs. *See* BENJAMIN LEE PRESTON, TOM LATOURRETTE, JAMES R. BROYLES, R.J. BRIGGS, DAVID CATT, CHRISTOPHER NELSON, JEANNE S. RINGEL & DANIEL A. WAXMAN, RAND CORP., *UPDATING THE COSTS OF COMPLIANCE FOR CALIFORNIA’S HOSPITAL SEISMIC SAFETY STANDARDS*, at ix (2019).

63. *E.g.*, Disclosure Statement at 17, *In re S. Inyo Healthcare Dist.*, No. 16-10015 (Bankr. E.D. Cal. Mar. 12, 2020), ECF No. 908; Disclosure Statement at 12, *In re Coalinga Reg’l Med. Ctr.*, No. 18-13677 (Bankr. E.D. Cal. Dec. 3, 2019), ECF No. 471.

64. *See supra* note 58 and accompanying text.

65. *See* Editorial, *supra* note 60.

causes like bad business decisions and competition no doubt play some part in hospitals' financial woes, and they are the dominant cause of some bankruptcies. But alongside those woes, national or statewide reductions in Medicare and Medicaid reimbursements have a substantial effect and drive many public hospitals into bankruptcy. Those hospitals—whose business models are based on revenues derived from those reimbursement programs—blame the reductions in their filings and their communities likewise recognize those reductions as a cause. Reductions in Medicare and Medicaid reimbursements, therefore, are the most influential systemic factor driving public hospitals into bankruptcy.

2. Population Decline

A secondary systemic factor of public-hospital bankruptcy is population decline. While hospitals rarely blame population decline explicitly, they do in a few cases. More often, the blame is indirect. And sometimes it is an unspoken but evident factor, especially in rural areas where population decline is unmistakable.

Here, as with Medicare and Medicaid, the causal mechanisms are discernible. Hospitals have high fixed costs—maintaining a building up to regulations, employing staff, and so on. As Natchez Regional Medical Center explained, the “operation of a modern general acute care hospital is largely a fixed cost business,” with “70-80% of the cost of providing services [being] fixed.”⁶⁶ The high fixed cost means that a small reduction in patients decreases revenue but does little to save expenses.

Likewise, when the population declines, the tax base does too. So when the population declines, even at the margin, a hospital may not be able to make ends meet with the decreased tax revenue.⁶⁷

A few hospitals note as much in their filings. For example, East Shoshone Hospital wrote that its “financial difficulties . . . arose, in part, from the declining population of East Shoshone County.”⁶⁸ Hardeman County Hospital, which filed in 2013, noted the county’s population declined from 3,890 in 1980 to 3,022 in 2000 to 2,642 in 2010.⁶⁹ Craig County Hos-

66. Disclosure Statement at 23, *In re Natchez Reg'l Med. Ctr.*, No. 14-01048 (Bankr. S.D. Miss. Aug. 29, 2014), ECF No. 410; *see also* Disclosure Statement at 21, *In re Craig Cnty. Hosp. Auth.*, No. 15-10277 (Bankr. N.D. Okla. Oct. 28, 2016), ECF No. 256.

67. *See, e.g.*, Disclosure Statement at 16, *In re Hardeman Cnty. Hosp. Dist.*, No. 13-70103, (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288.

68. Disclosure Statement at 2, *In re E. Shoshone Hosp. Dist.*, No. 00-20980 (Bankr. D. Idaho Oct. 6, 2000), ECF No. 21.

69. Disclosure Statement at 3, *In re Hardeman Cnty. Hosp. Dist.*, No. 13-70103, (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288.

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pital wrote that its population “has generally been decreasing likely due to continued migration from rural to urban areas.”⁷⁰

Other hospitals refer more obliquely to economic “declin[e],” which also suggests population outmigration.⁷¹ And many are in counties with declining populations, even if the filings do not mention that fact.⁷²

This result tracks other research as well, which attributes closures in rural hospitals to a continuous decline in rural populations.⁷³ That, in turn, has an outsize impact on public hospitals, which are disproportionately rural.

To sum up, the effect of population decline does not appear to be as strong as that of Medicare and Medicaid reductions. Only six hospitals mention it (of the 41 for which disclosure statements were available), and the causal mechanism is not as direct—patients may come from surrounding areas, or get better insurance, and so on. Nonetheless, population decline tends to press hospitals toward bankruptcy.

3. Minor Causes

In 2005, the *Los Angeles Times* won the Pulitzer Prize for their reporting on the gross malpractice at Los Angeles’s “Killer King” public hospital. The series revealed patients dying from routine procedures and healthy patients dropping dead in hospital care. “Staff fail[ed] to give patients crucial drugs or [gave] them toxic ones by mistake.”⁷⁴ Unsurprisingly, a study showed that King paid more in medical malpractice claims than any California hospital between 1999 and 2003. Corruption was rife too, with the *Times* writing that “King . . . spends inordinate sums on

70. Disclosure Statement at 21, *In re* Craig Cnty. Hosp. Auth., No. 15-10277 (Bankr. N.D. Okla. Oct. 28, 2016), ECF No. 256.

71. Disclosure Statement at 3-4, *In re* S. Humboldt Cmty. Healthcare Dist., No. 99-10200 (Bankr. N.D. Cal. May 5, 2000), ECF No. 89; Disclosure Statement at 3, *In re* Sierra Valley Hosp. Dist., No. 00-30288 (Bankr. E.D. Cal. June 28, 2002), ECF No. 66; Disclosure Statement at 4, *In re* S. Inyo Healthcare Dist., No. 99-16515 (Bankr. E.D. Cal. Feb. 6, 2003), ECF No. 172.

72. For example, Modoc County (home to Surprise Valley Hospital, which filed in 2018), saw its population decline from 9,686 to 8,700 between 2010 and 2020. *QuickFacts: Modoc County, California*, U.S. CENSUS BUREAU (2023), <https://www.census.gov/quickfacts/modoc-countycalifornia> [<https://perma.cc/DM5L-HEF5>]. Iron County, another 2018 filer, saw its population drop from 10,630 to 9,537 in the same window. *QuickFacts: Iron County, Missouri*, U.S. CENSUS BUREAU (2023), <https://www.census.gov/quickfacts/ironcountymissouri> [<https://perma.cc/CZ4V-8AYK>]. Union County, South Carolina, whose hospital filed in 2014, was also losing residents, from 28,961 to 27,244 in the 2010s. *QuickFacts: Union County, South Carolina*, U.S. CENSUS BUREAU (2023), <https://www.census.gov/quickfacts/unioncountysouthcarolina> [<https://perma.cc/XRL8-TW6E>].

73. Corcoran & Waddell, *supra* note 60, at 1-2.

74. Tracy Weber, Charles Ornstein & Mitchell Landsberg, *Deadly Errors and Politics Betray a Hospital’s Promise*, L.A. TIMES (Dec. 5, 2004), <https://www.latimes.com/local/la-me-kdday1dec05-story.html> [<https://perma.cc/A2W4-8ZQD>].

people who do little or no work.”⁷⁵ Employees billed far more overtime than their counterparts in nearby hospitals, and doctors received nearly twice the pay of their counterparts—while working less. This mismanagement was “no secret,” with dozens of audits and disciplinary reports attesting to the hospital’s failures.

The King story, while eye-catching, does not reflect the causes of most public-hospital bankruptcies. On occasion, public hospitals file for bankruptcy because of medical malpractice, embezzlement, gross mismanagement, or recession. But these instances are quite rare and account for far fewer bankruptcies than do reductions in reimbursements or population decline.

Medical Malpractice. Of the 41 bankruptcies with disclosure statements, not one mentions medical tort liability as a cause.⁷⁶ Indeed, only six of the hospitals even list tort claimants as a class of creditors.⁷⁷ So tort creditors do not drive public hospitals into bankruptcy.

Nor is the treatment of tort claimants a challenge to reorganizing hospitals. Each hospital carries insurance, often sufficient to cover the claims. When the insurance suffices, the tort creditor recovers in full, like a secured creditor. Otherwise, the tort creditor receives the full value of the insurance and the balance of the claim receives payment pro rata along with other unsecured creditors.⁷⁸

Embezzlement. The salacious tales of public corruption likewise account for few hospital bankruptcies. Among the 41 with disclosure statements, only three mention an associated criminal investigation into management.

Tulare Hospital’s bankruptcy was the most sensational. For years, the hospital struggled. The district’s management company, HCCA, had unchecked control over the operations and finances of the hospital—all district money was turned over to HCCA.⁷⁹

In 2017, new board members sought to wrest control of the hospital back from HCCA. After an election, they started asking management basic questions: Where is the district’s money deposited? What do we

75. Charles Ornstein, Tracy Weber & Steve Hyman, *Underfunding Is a Myth, But the Squandering Is Real*, L.A. TIMES (Dec. 6, 2004), <https://www.latimes.com/local/la-me-kdday2dec06-story.html> [<https://perma.cc/BTZ3-C64B>].

76. App. C (Disclosure Statements).

77. They were Coalinga, Pushmataha, Craig County, Union, Pauls Valley, and Natchez.

78. See Plan at 14, *In re Coalinga Reg’l Med. Ctr.*, No. 18-13677 (Bankr. E.D. Cal. Dec. 3, 2019), ECF No. 470; Plan at 16, *In re Pushmataha Cnty. – City of Antlers Hosp. Auth.*, No. 16-81001 (Bankr. E.D. Okla. Nov. 12, 2019), ECF No. 206; Plan at 30, *In re Craig Cnty. Hosp. Auth.*, No. 15-10277 (Bankr. N.D. Okla. Oct. 28, 2016), ECF No. 255; Plan at 9, *In re Union Hosp. Dist.*, No. 14-03299 (Bankr. D.S.C. June 1, 2015), ECF No. 169; Plan at 9, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 312; Plan at 26-27, *In re Natchez Reg’l Med. Ctr.*, No. 14-01048 (Bankr. S.D. Miss. Aug. 28, 2014), ECF No. 405.

79. Disclosure Statement at 8-12, *In re Tulare Local Healthcare Dist.*, No. 17-13797 (Bankr. E.D. Cal. May 22, 2019), ECF No. 1441.

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owe the management company and what are they charging us for? What is the district's cash position? HCCA stonewalled. Then, in September 2017, HCCA's head, Benny Benzeevi, announced that the district was broke and had only two options, accepting a loan from HCCA or shutting down. Two weeks later, the district filed its Chapter 9 petition.⁸⁰

A few months later, the FBI raided Benzeevi's home.⁸¹ He fled to the Philippines. But after revoking his passport, officials forced his return to the United States. He was arrested at the airport, sent to Tulare County and charged with (among many other crimes) embezzlement.⁸² In February 2024, Benzeevi reached a plea agreement and stands convicted of six felonies and two misdemeanors relating to his operation of the hospital.⁸³

But that is far from the ordinary case. In fact, the others ended with a whimper.

In 2013, Adair County Hospital, a rural Kentucky hospital, suddenly found itself with \$19 million in debt. That came as a surprise to residents, who once knew a hospital with no debt and resented the tax increases needed to service the debt.⁸⁴ But an audit found no theft or fraud, and authorities have not yet brought charges.⁸⁵

Likewise, Southern Humboldt Hospital mentioned an ongoing FBI investigation in its disclosure statement.⁸⁶ But no further information suggests that the investigation resulted in a criminal prosecution.

Gross Mismanagement. As with embezzlement, gross mismanagement rarely drives public hospitals into bankruptcy. "Mismanagement" is difficult to define, as any bankruptcy at least suggests management could be improved. And indeed, it is regular for filings to cursorily list "bad management" as part of what drove them into bankruptcy.⁸⁷ But a nar-

80. *Id.*

81. Alyssa Rege, *FBI Raids Home of Former CEO of Tulare Regional Medical Center, Seizes Items Related to Management of Hospital*, BECKER'S HOSP. REV. (Apr. 24, 2018), <https://www.beckershospitalreview.com/legal-regulatory-issues/fbi-raids-home-of-former-ceo-of-tulare-regional-medical-center-seizes-items-related-to-management-of-hospital.html> [<https://perma.cc/N3V4-N2FA>].

82. Sun-Gazette Staff, *HCCA Chief Executive Benny Benzeevi Arrested at LAX*, SUN-GAZETTE (Dec. 9, 2020), <https://thesungazette.com/article/news/2020/12/09/hcca-chief-executive-benny-benzeevi-arrested-at-lax-2> [<https://perma.cc/Z5GL-654T>].

83. Press Release, Off. of the Dist. Att'y, Cnty. of Tulare, *Guilty Plea in Tulare Hospital Case*, (Feb. 10, 2024), <https://tulareda.org/guilty-plea-in-tulare-hospital-case> [<https://perma.cc/QRB7-WT4H>].

84. *KSP Investigating Local Hospitals*, WAVE (Jan. 18, 2013), <https://www.wave3.com/story/19538280/ksp-investigating-18000000-debt-at-local-hospital> [<https://perma.cc/W23B-4K7Q>].

85. *Id.*

86. Disclosure Statement at 3, *In re S. Humboldt Cmty. Healthcare Dist.*, No. 99-10200 (Bankr. N.D. Cal. May 4, 2000), ECF No. 89.

87. *E.g.*, Disclosure Statement at 5, *In re Adair Cnty. Hosp. Dist.*, No. 13-10940 (Bankr. W.D. Ky. Dec. 18, 2015), ECF No. 316 (citing "[y]ears of excessive borrowing to fund poor man-

rower definition—one focused on whether the hospital district sued its prebankruptcy management—better captures the kind of King-style mismanagement that plays a definitive role in pushing a hospital into bankruptcy.⁸⁸ Such mismanagement is rare: only two of 41 disclosure statements mentioned suits against managers of the hospital.

Natchez Regional Medical Center's 2009 bankruptcy was one. There, before bankruptcy, the district sued Quorum Health Resources for \$46 million for breach of their management agreement.⁸⁹ For a hospital with liabilities in the range of \$10 million to \$50 million, mismanagement of that magnitude could well have pushed them into bankruptcy.⁹⁰ The case ultimately settled for \$15 million, enough to be the cause of the bankruptcy.⁹¹

The other case of gross mismanagement also featured Quorum. In Watonga Hospital's 2004 bankruptcy, the hospital had a similar management agreement with Quorum.⁹² Quorum's operations resulted in large overpayments from Medicare, in turn forcing the hospital to repay Medicare—something it could not afford.⁹³ (Medicare had a claim for \$1.2 million and the hospital had operating revenues of \$3.5 million.⁹⁴) When the district terminated Quorum's contract for that mismanagement, Quorum sued for management fees under the contract; the district counterclaimed for mismanagement.⁹⁵ Ultimately, Quorum settled with the district for \$250,000, and Medicare in turn accepted that \$250,000 to settle the overpayments incurred by Quorum.⁹⁶

Recessions. Somewhat surprisingly, recessions do not appear to drive public hospitals into bankruptcy. That is unexpected because in a recession, patients are more likely to lose jobs and hence hospitals are more

agement"); Disclosure Statement at 17, *In re Chambers Cnty. Hosp. Dist. No. 1*, No 00-80240 (Bankr. S.D. Tex. July 1, 2003), ECF No. 109 (citing "the lack of consistent and continual financial management").

88. Necessarily, there are limits to this metric, as some management may be judgment-proof or otherwise not worth suing. That said, the available information from disclosure statements and local news about the various other bankruptcies does not suggest that gross mismanagement of the type seen in Watonga and Natchez is a driving factor in those bankruptcies.

89. Complaint at 51, *Natchez Reg'l Med. Ctr. v. Quorum Health Res., LLC*, No. 09-cv-207 (S.D. Miss. Dec. 7, 2009).

90. Petition at 1, *In re Natchez Reg'l Med. Ctr.*, No. 09-00477 (Bankr. S.D. Miss. Feb. 12, 2009), ECF No. 1.

91. Vershal Hogan, *Adams County Supervisors 'Upset' with Natchez Regional Medical Center Bankruptcy*, NACHEZ DEMOCRAT (Feb. 6, 2014) <https://www.natchezdemocrat.com/2014/02/06/adams-county-supervisors-upset-with-natchez-regional-medical-center-bankruptcy> [<https://perma.cc/UXV3-FVJG>].

92. Disclosure Statement at 10, *In re Watonga Hosp. Tr. Auth.*, No. 04-10415 (Bankr. W.D. Okla. Jan. 10, 2006), ECF No. 61.

93. *Id.*

94. *Id.* at 18 (Medicare claim); *id.* at 39 (operating revenues).

95. *Id.* at 10-12.

96. *Id.* at 13. For a similar example, see Disclosure Statement at 23, *In re Palm Drive Health Care Dist.*, No. 14-10510 (Bankr. N.D. Cal. Mar. 15, 2019), ECF No. 481.

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likely to lose private payors and the higher reimbursement rates they offer. The shift, in turn, from private payors to Medicaid, charitable care, or self-pay would hurt revenues and could have been expected to push the hospitals toward bankruptcy.

Yet recessions do not seem to have much of an effect. Between 1988 and 2021—that is, the years encompassing the bankruptcy data set reviewed in this Article—the United States entered periods of recession from August 1990 to March 1991, April to November 2001, January 2008 to June 2009, and March to April 2020.⁹⁷ Those periods include just five of the 55 bankruptcies. Indian Valley Hospital filed in February 1991.⁹⁸ Whitney Hospital filed in April 2001.⁹⁹ Alta Hospital filed in August 2001.¹⁰⁰ Hall County Hospital filed in October 2001.¹⁰¹ And Natchez Regional Medical Center filed for bankruptcy in February 2009.¹⁰²

Recession periods total 35 months of the 33-year stretch, or around 8.8% of the time. Meanwhile, the five recession bankruptcies amount to about 9.1% of the 55 bankruptcies. This may suggest either that the effect of a recession is not meaningful for hospital revenues, or that some other forms of assistance counterbalance the recession and help stabilize public hospitals in tough times. Either way, though, recessions do not appear to cause many public hospital bankruptcies.

4. The Final Straw

As a final point, it is worth noting that these long-term causes typically force a public hospital into bankruptcy by creating a liquidity crisis. That is, lower reimbursement rates result in the hospital running out of cash to maintain operations.

A look at the cases reveals this common theme of liquidity crises. In describing the immediate cause of the filing, hospitals typically point to a shortage of cash on hand.¹⁰³ Mendocino had 2.3 days' cash on hand and

97. *NBER Based Recession Indicators for the United States from the Period Following the Peak Through the Trough*, FED. RSRV. BANK OF ST. LOUIS (Mar. 1, 2024), <https://fred.stlouisfed.org/series/USREC> [<https://perma.cc/NHH6-JK39>].

98. Petition, *In re* Indian Valley Hosp. Dist., No. 91-21089 (Bankr. E.D. Cal. Feb. 13, 1991), ECF No. 1.

99. Petition, *In re* Whitney Hosp. Auth., No. 01-60808 (Bankr. W.D. Tex. Apr. 10, 2001), ECF No. 1.

100. Petition, *In re* Alta Healthcare Dist., No. 01-17857 (Bankr. E.D. Cal. Aug. 21, 2001), ECF No. 1.

101. Petition, *In re* Hall Cnty. Hosp. Dist., No. 01-21283 (Bankr. N.D. Tex. Oct. 31, 2001), ECF No. 1.

102. Petition, *In re* Natchez Reg'l Med. Ctr., No. 09-00477 (Bankr. S.D. Miss. Feb. 12, 2009), ECF No. 1.

103. Some of this has to do with Chapter 9's strict insolvency requirement, which prevents hospitals from filing until they experience cash-flow insolvency. *See* 11 U.S.C. § 109(c)(3) (2018).

expected to run out of cash in about a month when it filed.¹⁰⁴ Coalinga Regional Medical Center, in its 2018 bankruptcy, also filed with less than a month's worth of cash on hand.¹⁰⁵ Chambers County Hospital filed for a different liquidity issue—they lacked cash to pay the utility bills and needed bankruptcy to (literally) keep the lights on.¹⁰⁶ Craig County Hospital, Southern Inyo Hospital, Kennewick Hospital, and Tulare Regional Medical Center all filed after missing payroll.¹⁰⁷

Conversely, public hospitals seldom blame a run on their assets—the traditional rationale given for businesses turning to bankruptcy—for the need to file.¹⁰⁸ In fact, for many debts, creditor runs are impossible for a public hospital. States often prevent creditors from executing judgments against local governments of all types, meaning that creditors *cannot* start a run on the assets.¹⁰⁹

104. Disclosure Statement at 11, *In re Mendocino Coast Health Care Dist.*, No. 12-12753 (Bankr. N.D. Cal. Dec. 15, 2014), ECF No. 162; *Mendocino Coast District Hospital to Declare Chapter 9 Bankruptcy*, BECKER'S HOSP. REV. (Oct. 5, 2012) <https://www.beckershospitalreview.com/finance/mendocino-coast-district-hospital-to-declare-chapter-9-bankruptcy.html> [<https://perma.cc/2L8F-H5BM>].

105. Disclosure Statement at 13, *In re Coalinga Reg'l Med. Ctr.*, No. 18-13677 (Bankr. E.D. Cal. Dec. 3, 2019), ECF No. 471. Other public hospitals referenced urgent solvency issues as well. *See, e.g.*, Disclosure Statement at 12, *In re Bamberg Cnty. Mem'l Hosp.*, No. 11-03877 (Bankr. D.S.C. Feb. 10, 2012), ECF No. 141 (“facing a liquidity crisis”); Disclosure Statement at 6, *In re Palm Drive Health Care Dist.*, No. 07-10388 (Bankr. N.D. Cal. Apr. 30, 2009), ECF No. 169 (“serious cash shortfall”); Disclosure Statement at 15, *In re Sierra Kings Health Care Dist.*, No. 09-19728 (Bankr. E.D. Cal. Nov. 7, 2011), ECF No. 1068 (“facing a liquidity crisis”).

106. Disclosure Statement at 16, *In re Chambers Cnty. Hosp. Dist.* No. 1, No. 00-80240 (Bankr. S.D. Tex. July 1, 2003), ECF No. 109. Incidentally, Section 366 of the Bankruptcy Code addresses utility-service issues and reinforces the argument that much of what the Code aims to do is respond to liquidity crunches. *See* 11 U.S.C. § 366 (2018).

107. First-Day Declaration at 7, *In re Craig Cnty. Hosp. Auth.*, No. 15-10277 (Bankr. N.D. Okla. Mar. 4, 2015), ECF No. 10 (“could not have made payroll”); Disclosure Statement at 18, *In re S. Inyo Healthcare Dist.*, No. 16-10015 (Bankr. E.D. Cal. Mar. 12, 2020), ECF No. 908 (“inability to pay ordinary operating expenses, including payroll and vendor obligations”); Disclosure Statement at 28, *In re Kennewick Pub. Hosp. Dist.*, No. 17-02025 (Bankr. E.D. Wash. May 11, 2018), ECF No. 846; Ayla Ellison, *California Hospital Files for Bankruptcy After Missing Payroll*, BECKER'S HOSP. REV. (Oct. 3, 2017), <https://www.beckershospitalreview.com/finance/california-hospital-files-for-bankruptcy-after-missing-payroll.html> [<https://perma.cc/Z752-9TBN>] (noting that, at Tulare Regional Medical Center, “several nurses and other staff walked off the job after not being paid”). Another common form of liquidity crisis has arisen when Medicare has withheld future payments after concluding that it has overpaid the hospital in the past. This recoupment immediately cripples a hospital's major revenue stream and leads to a liquidity-based bankruptcy filing. *See, e.g.*, Disclosure Statement at 2, *In re E. Shoshone Hosp. Dist.*, No. 00-20980 (Bankr. D. Idaho Oct. 6, 2000), ECF No. 21; Disclosure Statement at 3, *In re Lost Rivers Dist. Hosp.*, No. 10-40344 (Bankr. D. Idaho Dec. 9, 2010), ECF No. 61; Disclosure Statement at 5-6, *In re Iron County Hosp. Dist.*, No. 18-10111 (Bankr. E.D. Mo. Dec. 9, 2019), ECF No. 249.

108. *See* THOMAS H. JACKSON, *THE LOGIC AND LIMITS OF BANKRUPTCY LAW* 8-10 (1986).

109. *E.g.*, WASH. REV. CODE § 6.17.080 (2023). The exception to this rule is that a higher level of government can attach the assets of a public hospital. In those rare cases, a creditor grab race can be responsible for the bankruptcy filing, though it is usually just part of the reason. *See, e.g.*, Disclosure Statement at 13, *In re Bamberg Cnty. Mem'l Hosp.*, No. 11-03877 (Bankr. D.S.C. Feb. 10, 2012), ECF No. 141 (indicating that the South Carolina Department of Revenue froze the hospital's assets).

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The role of bankruptcy in ameliorating a liquidity crisis has been acknowledged by scholars, but never as the primary purpose of bankruptcy. David Skeel and Kenneth Ayotte, for example, show how various Code provisions—administrative expense priority, free-and-clear sales, and coerced loans—angle at providing liquidity rather than preventing creditor runs for businesses.¹¹⁰ Likewise, Vince Buccola and Laura Coordes have recognized the role of bankruptcy in eliminating a debt overhang (one form of liquidity crisis) in the context of political subdivisions.¹¹¹

Public-hospital bankruptcies, then, take these theoretical arguments one step further. They offer an on-the-ground example of a class of cases (government businesses) in which bankruptcy law acts primarily as a liquidity provider, and only secondarily (if at all) to prevent a creditor run.

B. Entering Bankruptcy: What Bankrupt Public Hospitals Look Like

The typical bankrupt public hospital differs from the typical bankrupt business in two ways: size and centrality to its community. Most businesses in bankruptcy are small businesses with limited impact in their communities.¹¹² Large businesses, the focal point of scholarship, tend to be corporate groups with nationwide operations that are often untethered to the district where they file for bankruptcy.¹¹³

In contrast, public hospitals' filings reveal that most of them are medium-sized businesses that play central roles in their communities. This is especially true for the 34 hospitals (of 41 disclosure statements) that categorize themselves as rural.¹¹⁴ Urban hospitals also play a central role by dint of their sheer size. All the hospitals provide substantial employment and interact with suppliers, banks, bondholders, and more, enmeshing them in their communities as key institutions.

Start with the assets, which each hospital estimates in its petition.¹¹⁵

110. Kenneth Ayotte & David A. Skeel Jr., *Bankruptcy Law as a Liquidity Provider*, 80 U. CHI. L. REV. 1557, 1589-1601 (2013) (detailing “bankruptcy law’s liquidity-providing rules”).

111. Vincent S.J. Buccola, *An Ex Ante Approach to Excessive State Debt*, 64 DUKE L.J. 235, 272 (2014); Coordes, *supra* note 23, at 343, 346.

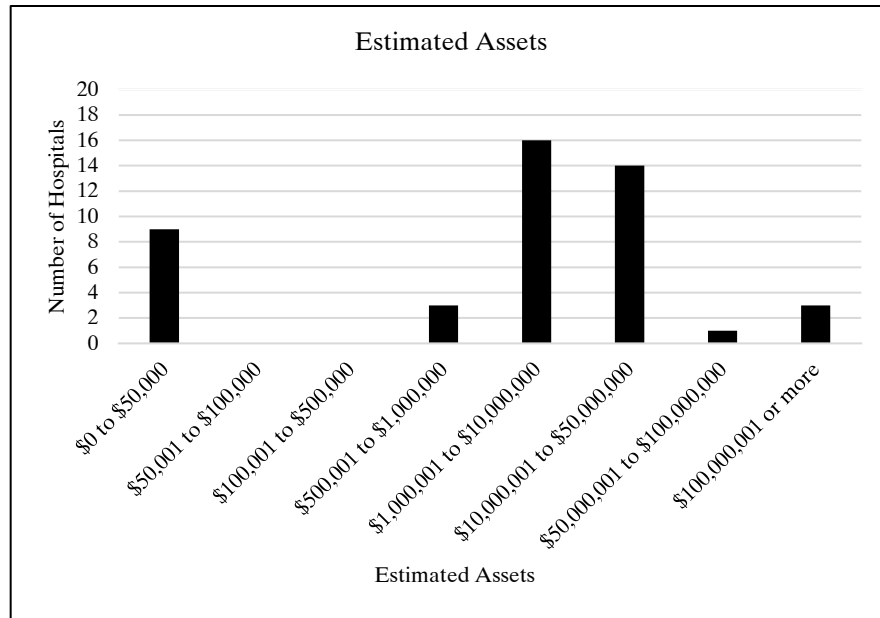
112. See Douglas G. Baird & Edward R. Morrison, *Serial Entrepreneurs and Small Business Bankruptcies*, 105 COLUM. L. REV. 2310, 2310-11 (2005).

113. See Laura Napoli Coordes, *The Geography of Bankruptcy*, 68 VAND. L. REV. 381, 382-84 (2015) (noting that General Motors filed for bankruptcy in New York even though it lacked any meaningful business operations there).

114. App. C (Disclosure Statements)

115. App. B (Petitions).

Figure 2



Following Edward Morrison’s work on small-business bankruptcy, I take \$1 million in assets as the cutoff between small- and medium-sized businesses.¹¹⁶ And I use \$100 million in assets as the cutoff between medium-sized and large businesses to mirror Lynn LoPucki’s large-business database.¹¹⁷ What the petitions reveal, then, is that most of the hospitals are medium-sized enterprises. Of the 47 hospital petitions that reported estimated assets, 31 hospitals had assets between \$1 million and \$100 million.

The 12 “small” hospitals, with fewer than \$1 million each in assets, are rural hospitals in sparsely populated areas. By way of example, Lost

116. See Edward R. Morrison, *Bankruptcy’s Rarity: An Essay on Small Business Bankruptcy in the United States*, 5 EUR. CO. & FIN. L. REV. 172, 176 n.7 (2008) (citing Arturo Bris, Ivo Welch & Ning Zhu, *The Costs of Bankruptcy: Chapter 7 Liquidation Versus Chapter 11 Reorganization*, 61 J. FIN. 1253, 1282 (2006)).

117. See *What Is the BRD?*, FLORIDA-UCLA-LOPUCKI BANKR. RSCH. DATABASE (Dec. 2022), <https://lopucki.law.ufl.edu/index.php> [<https://perma.cc/F2BY-DZ8N>]. Lynn LoPucki uses 1980 dollars and adjusts for inflation. The petitions filed by hospitals do not adjust for inflation, and unfortunately they are the only consistent documents accessible in the cases that provide asset and liability statistics. That said, the buckets are large enough and the time period condensed enough that even adjusting for inflation it does not seem likely to shift a hospital from one category to the next. And for the hospitals where there are precise figures for assets and liabilities, none involved a case where the real value and the nominal value were in different buckets.

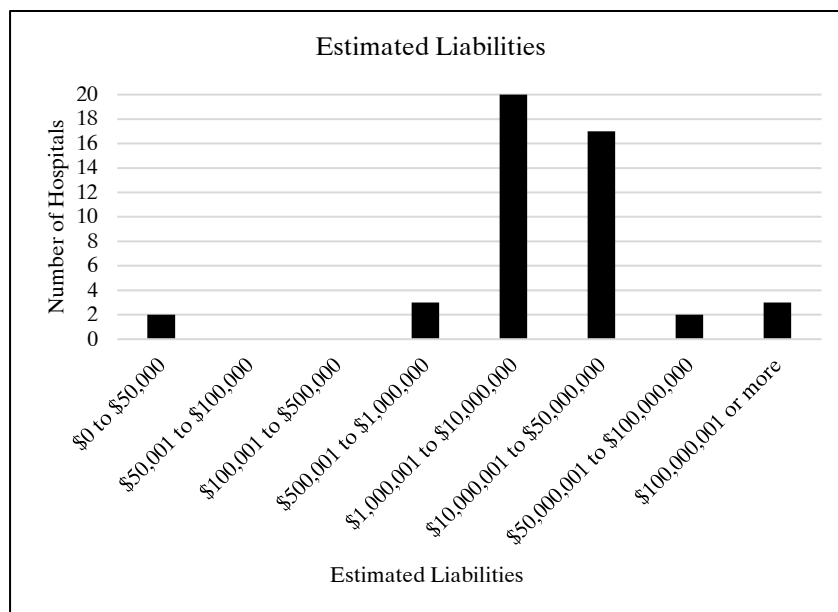
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Rivers Hospital served a population of 7,000 over 5,225 square miles.¹¹⁸ Watonga Hospital sits in Blaine County, Oklahoma, with a population of 8,735 (spread over 928 square miles).¹¹⁹

The larger hospitals do not follow a consistent pattern. Tulare Hospital owned significant real estate, some of which was unrelated to the hospital business.¹²⁰ Valley Health System was a large hospital system: it owned four hospitals, comprising 632 beds and serving a population of 360,000 over 882 square miles.¹²¹ Kennewick Hospital served three cities (Kennewick, Pasco, and Richland), in a metro area of 300,000.¹²²

The story is similar with liabilities.¹²³

Figure 3



118. Disclosure Statement at 2, *In re* Lost Rivers Dist. Hosp., No. 10-40344 (Bankr. D. Idaho Dec. 9, 2010), ECF No. 61.

119. *QuickFacts: Blaine County, Oklahoma*, U.S. CENSUS BUREAU (July 1, 2023), <https://www.census.gov/quickfacts/blainecountyoklahoma> [<https://perma.cc/6HEN-GYJS>]. This data is for 2020.

120. Disclosure Statement at 19-20, *In re* Tulare Local Healthcare Dist., No. 17-13797 (Bankr. E.D. Cal. May 22, 2019), ECF No. 1441.

121. Disclosure Statement at 6, *In re* Valley Health Sys., No. 07-18293 (Bankr. C.D. Cal. Nov. 2, 2009), ECF No. 614.

122. Disclosure Statement at 23, *In re* Kennewick Pub. Hosp. Dist., No. 17-02025-9 (Bankr. E.D. Wash. May 11, 2018), ECF No. 846.

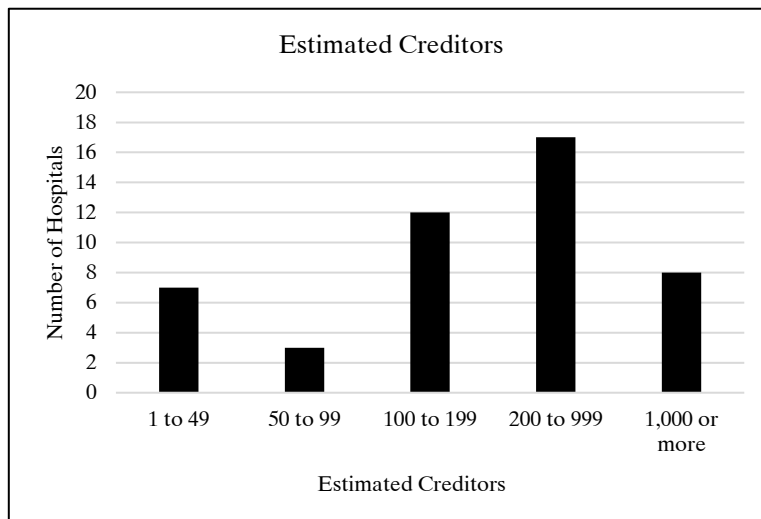
123. App. B (Petitions).

Thirty-nine of the 48 hospitals that reported liabilities estimated them to be between \$1 million and \$100 million.¹²⁴ The three hospitals with over \$100 million in liabilities are the same as those with over \$100 million in assets.¹²⁵ And three of the four with liabilities under \$1 million also had assets under \$1 million.¹²⁶

This makes sense and suggests that hospital credit generally is sensible—hospital debt loads roughly track the value of the assets.¹²⁷ So hospitals are not having trouble borrowing up to their value, and lenders are not extending credit far beyond a hospital's value.

The hospital petitions' estimated numbers of creditors also reinforce the data showing public hospitals to be medium-size enterprises enmeshed in the local economy.

Figure 4



124. The Code now allows for “small business” reorganizations for debtor corporations with up to \$7.5 million in liabilities. See 11 U.S.C. § 1182(1)(A) (2018). Before the pandemic, that limit was \$2.7 million. See William D. Curtis, James S. “Charlie” Livermon III & Richard A. Prosser, *Congress Temporarily Raises Subchapter V Debt Limit. Again.*, NAT’L L. REV. (June 8, 2022), <https://www.natlawreview.com/article/congress-temporarily-raises-subchapter-v-debt-limit-again> [https://perma.cc/UA9Z-26V2].

125. App. B (Petitions).

126. *Id.* Hall County Hospital is the exception. That hospital had more assets than liabilities when it filed, caused by inefficient payment collection. See Disclosure Statement at 18-19, *In re Hall Cnty. Hosp. Dist.*, No. 01-21283 (Bankr. N.D. Tex. Aug. 28, 2002), ECF No. 54.

127. This holds fairly well for each range too. For example, the number of hospitals with \$1 to \$10 million in liabilities (16) roughly matches those with \$1 million to \$10 million in assets (20). See App. B (Petitions).

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These data reveal hospitals that have significant economic footprints. Those claims tend to be those of employees, suppliers, local banks, and so on. And even when the dollar values of such claims are low, the number of creditors itself reveals that hospitals interact economically with wide swaths of their communities.

Coalinga Regional Medical Center, for example, listed the following businesses in its ZIP code as creditors (plus governmental and individual creditors excluded here): California Water Services, Cambridge Inn, Central Valley Cable TV, Coalinga Hardware, Gilberts Milk Service, K-Mart, Law Offices of Frame & Matsumoto, Service Pharmacy, West Hills Oil Incorporated, and Westside Supply.¹²⁸

Even Watonga, a small, rural hospital, listed many local businesses as creditors. Among them: Clewell Family Hardware, Duckwall-Alco Stores, Eagle Auto Parts, Great Plains Regional Medical, Karl's Apple Market, Kiwanis Club of Watonga, SOS Salvage and Wrecker Service, TC 159 Watonga Training Site, Watonga Building Center, Watonga Machine Steel Works, Watonga Plumbing and Electric, Watonga Republican, and various individuals and government entities.¹²⁹

But the best example of hospitals as central economic institutions is employment. Large urban hospitals, like Kennewick Hospital, naturally employ many. But the mine-run hospitals are the real story because they are cornerstone employers in their area. Jack County Hospital's 236 employees made it "one of the largest employers in the county."¹³⁰ Gainesville Hospital's 286 made the hospital the sixth-largest employer in its county.¹³¹ Hardeman County Hospital's 85 made it second-largest in its county.¹³² Even small hospitals, like Watonga Hospital (assets and liabilities under \$1 million), can employ dozens; there, it was 70.¹³³

128. See Petition, Schedule F, *In re Coalinga Reg'l Med. Ctr.*, No. 03-14147 (Bankr. E.D. Cal. May 1, 2003), ECF No. 1. It also listed governmental and individual creditors.

129. See Creditor List, *In re Watonga Hosp. Tr. Auth.*, No. 04-10415 (Bankr. W.D. Okla. June 26, 2006), ECF No. 76.

130. Disclosure Statement at 12, *In re Jack Cnty. Hosp. Dist.*, No. 20-42012, (Bankr. N.D. Tex. Nov. 23, 2020), ECF No. 61.

131. Disclosure Statement at 3, *In re Gainesville Hosp. Dist.*, No. 17-40101 (Bankr. E.D. Tex. Oct. 5, 2018), ECF No. 190.

132. Disclosure Statement at 14-15, *In re Hardeman Cnty. Hosp. Dist.*, No. 13-70103, (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288.

133. Disclosure Statement at 9, *In re Watonga Hosp. Tr. Auth.*, No. 04-10415 (Bankr. W.D. Okla. Jan. 10, 2006), ECF No. 61.

Hospital	Employees ¹³⁴
Jack County Hospital	236
Coalinga Medical Center (2018 filing)	200
Iron County Hospital	100
Tulare Hospital	524
Kennewick Hospital	1136
Gainesville Hospital	286
Atoka County Hospital	115
Pushmataha County Hospital	112
Southern Inyo Hospital (2016 filing)	103 (Full-Time Equivalents)
Craig County Hospital	190
Union Hospital	518
Palm Drive Hospital (2014 filing)	242
Natchez Medical Center (2014 filing)	300 (Full-Time Equivalents)
Adair County Hospital	250
Hardeman County Hospital	85
Pauls Valley Hospital	150
Mendocino Coast Hospital	285
Barnwell County Hospital	120
Bamberg County Memorial Hospital	91
Sierra Kings Hospital	324
Palm Drive Hospital (2007 filing)	286
Tri-City Mental Health Center	213
Watonga Hospital	70
Coalinga Medical Center (2003 filing)	113
Hall County Hospital	12
Chambers County Hospital	57
East Shoshone Hospital	1
Southern Humboldt Hospital	95
Los Medanos Hospital	450
Sierra Valley Hospital	70
Chowchilla Memorial Hospital	66
Southern Inyo Hospital (1999 filing)	90
Corcoran Hospital District	80

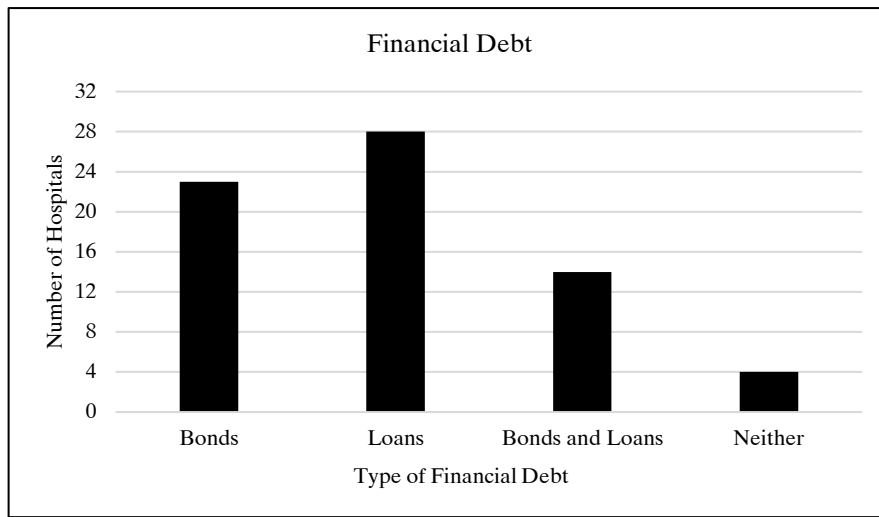
As for the financial debts, nearly all the public hospitals have some. They rely on both bank loans and bonds, with loans being somewhat more common.¹³⁵ Revenue bonds are more common than general-obligation bonds.¹³⁶ And loans tend to be secured.

134. App. C (disclosure statements). Hospitals are not required to report this figure, so some do not. Many also do not provide a breakdown of full-time, part-time, or full-time equivalent employees, so these data may not be consistent across hospitals. For details, see notes to Appendix C.

135. *Id.*

136. The Code's definition of "special revenues" is broad, so it can cover tax revenues in addition to patient or government payments to the hospital. *See* 11 U.S.C. §§ 902(2), 928 (2018). Basically, that means you can lend to a municipal project and get a security interest that will be respected in bankruptcy easily.

Figure 5



Loans. It comes as little surprise that the loans are secured, as banks often require collateral for their loans. Also unsurprising is the type of bank: regional ones rather than national ones, like Spirit of Texas Bank,¹³⁷ United Mississippi Bank,¹³⁸ and Bank of the Sierra.¹³⁹ That again reinforces the tether public hospitals have to their communities and underscores their role as central community institutions.

Bonds. For bonds, the skew toward secured finance is a bit more surprising. Corporations issue unsecured bonds routinely,¹⁴⁰ and many governmental bonds are unsecured, general-obligation bonds.¹⁴¹ That said, the explanation for the near-exclusive use of secured bonds here may be a simple one: distress. A hospital in poor financial condition may need to give creditors extra assurances of repayment, and one such assurance is a security interest that guarantees the creditor payment ahead of unsecured creditors. Further, the Bankruptcy Code respects that priority

137. Plan at 8, *In re Jack County Hosp. Dist.*, No. 20-42012 (Bankr. N.D. Tex. Oct. 4, 2021), ECF No. 128.

138. Plan at 7, *In re Natchez Reg'l Med. Ctr.*, No. 09-00477 (Bankr. S.D. Miss. Nov. 4, 2009), ECF No. 527.

139. Disclosure Statement at 5, *In re Alta Healthcare Dist.*, No. 01-17857 (Bankr. E.D. Cal. June 2, 2004), ECF No. 406.

140. See Efraim Benmelech, Nitish Kumar & Raghuram Rajan, *The Decline of Secured Debt* 1-2 (Nat'l Bureau of Econ. Rsch. Working Paper No. 26637, 2021) (noting that secured debt has declined over time and is also countercyclical).

141. See Peter Molk, Comment, *Broadening the Use of Municipal Mortgages*, 27 YALE J. ON REGUL. 397, 402-03 (2010).

and extends the security interest to after-acquired property, making secured finance a potent tool for distressed local governments.¹⁴²

Hospitals take a variety of approaches toward the proportion of secured finance. Some rely almost entirely on secured finance; others have little secured debt. And there is every combination in between as well. Those hospitals that filed schedules listing their secured and unsecured debts¹⁴³ offer a helpful glimpse into the variety of financing mechanisms.¹⁴⁴

Hospital	Secured Debt	Unsecured Debt	Percentage of Secured Debt
Palm Drive Hospital (2014 filing)	\$440,925	\$4,897,848	8.3%
Natchez Regional Medical Center (2009 filing)	\$28,223,933	\$3,773,972	88.2%
Natchez Regional Medical Center (2014 filing)	\$15,557,710	\$5,247,414	74.8%
Lost Rivers Hospital	\$1,136,968	\$2,161,512	34.5%
Adair County Hospital	\$3,825,893	\$7,124,832	34.9%
Pauls Valley Hospital	\$5,083,432	\$3,934,538	56.4%
Union Hospital	\$2,002,842	\$45,643	97.8%
Pushmataha County Hospital	\$5,860,948	\$3,689,834	61.4%
Southern Inyo (2016 filing)	\$1,998,535	\$4,501,775	30.7%

All this is to say that there is more than one way to finance a hospital. So rather than a uniform model of raising capital, hospitals have a variety of mechanisms available to them, and in fact take advantage of that variety based on the particularities of any given hospital's financial situation. But those financing choices do not appear to make a difference when it comes to hospital distress.

In sum, public hospitals that file for bankruptcy tend to be medium-sized enterprises that are central to the community. That centrality stems not only from providing healthcare, but also from employment and commercial relationships that span the community.

142. See 11 U.S.C. § 928 (2018). The definition of "special revenues" is quite broad, including "receipts derived from the ownership, operation or disposition" of a project as well as "taxes specifically levied to finance one or more projects." *Id.* § 902(2)(A), (E). So nearly any security interest in a public hospital will qualify as a special revenue because it is either tied to the overall revenues of the hospital or to a particular tax used to fund the hospital. The result is that it is easy for bondholders who want a security interest to obtain it from a public hospital and be assured of repayment ahead of other creditors. See Amdursky, *supra* note 29, at 4-7.

143. Governments that file for bankruptcy need not file schedules listing the amount of secured and unsecured debt they owe, unlike typical businesses. See FED. R. BANKR. P. 1007(b)(1); *cf.* 11 U.S.C. § 924 (2018) (requiring the typical debtor business to provide a list of creditors). Some hospitals do file those schedules anyway and hence those filings are the source of the data here.

144. App. C (Disclosure Statements).

C. In Bankruptcy

As with all debtors, public hospitals must figure out how to meet their cash needs in bankruptcy. Sometimes, as with corporate debtors, the hospitals have sufficient unencumbered assets to continue operations without obtaining additional sources of cash.

When they do not, though, public hospitals turn to four other mechanisms: debtor-in-possession (DIP) loans, tax increases, bonds, and hibernation. Here the public debtors diverge sharply from corporate debtors. Where corporations make use of DIP loans routinely, public hospitals do so infrequently. Instead, they rely on taxation, which private corporations cannot do. Sometimes, the tax revenues are used to back bond issuances or in conjunction with bond issuances (which are unheard of for corporate debtors). And sometimes the hospitals hibernate, closing operations until they sort out their finances (which is rare, though not unheard of, in corporate insolvency).

DIP Financing. DIP financing is capital received by a debtor after it files for bankruptcy. DIP financing is often the only access to capital for a large corporate debtor, so it is a feature of nearly every case¹⁴⁵ and becomes the case's centerpiece. Increasingly in large corporate bankruptcies, DIP loans include terms that dictate bankruptcy outcomes, or at least substantial aspects of cases, like selling off a corporate division or closing a plant.¹⁴⁶

Public hospitals, by contrast, use DIP financing infrequently. Of the 55 cases,¹⁴⁷ only seven had a DIP loan.¹⁴⁸ This contrast likely results from two key differences in public and private bankruptcy. First, in a public bankruptcy, the debtor may have other revenue sources, like taxes, which many public hospitals rely on. Second, the limits of a Chapter 9 bankruptcy prevent DIP lenders from receiving certain benefits, like the installation of new management or being able to dictate the outcome of the

145. Kenneth Ayotte & Jared A. Elias, *Bankruptcy Process for Sale*, 39 YALE J. ON REGUL. 1, 6 n.21 (2022) (reporting that 94% of "major" bankruptcies between 2004 and 2012 used DIP financing or its equivalent).

146. *Id.*

147. Information on DIP financing comes from the cases' dockets as courts must approve such financing. Because all dockets were available, this is a full set of the 55 cases.

148. App. A (Dockets). In three cases, the loan appears to have been made by a future purchaser: Universal Health Services took over Gainesville Hospital; Adventist Health took over Tulare Hospital; Cadira attempted to buy Surprise Valley Hospital. In three others, the lender was a local bank: Jack County Hospital's lender was Spirit of Texas Bank (the hospital reorganized rather than sell); Chambers County Hospital's lender was Security State Bank (it reorganized too); Craig County Hospital's lender was First National Bank of Vinita. Last, Atoka County's lender, IPFS, was just providing funding to pay for the hospital's insurance premiums—not finance the whole bankruptcy. *See* notes to App. A (Dockets).

bankruptcy.¹⁴⁹ So both debtor hospitals and lenders have fewer reasons to use DIP financing when hospitals need more capital in bankruptcy.

Tax Increases. One option available to government debtors is increasing taxation, which can increase revenues.¹⁵⁰ Private corporations cannot tax, so taxation is never a funding mechanism in Chapter 11.

Yet in Chapter 9, taxation is a means of finance. Communities regularly vote to increase their own taxes to sustain their hospital, funding the hospital's bankruptcy in the near term and helping stabilize its finances going forward.

By way of example, Watonga Hospital voters extended a 1% excise tax to fund their bankruptcy.¹⁵¹ Adair County Hospital levied a new tax of 3.7 cents per \$100 of assessed property to fund its bankruptcy.¹⁵² Pauls Valley Hospital voters¹⁵³ and Iron County Hospital voters¹⁵⁴ both approved half-cent sales taxes to fund their hospitals.

Bond Financing. Though uncommon, some hospitals resolve their cash issues in bankruptcy by issuing bonds. The bonds can be in place of, or in addition to, new taxes as a funding mechanism. This contrasts with private debtors, who never issue bonds to fund their bankruptcy.

As an example, take Gainesville Hospital. It had various debts and chose to pay everyone—even unsecured creditors—in full. The hospital lacked the cash to pay upfront, so it received approval from the state to issue bonds sufficient to repay all prebankruptcy debts and bankruptcy expenses.¹⁵⁵ The result was that creditors were paid in full and the district now uses its revenues to pay one major debt (bonds) on a planned, manageable schedule, instead of paying many debts at varying times that may not be convenient for the district. Meanwhile, the district entered into a management agreement to save costs and stabilize the hospital.¹⁵⁶

149. Cf. Section II.A (discussing federalism limits in Chapter 9).

150. Information on tax increases, bond issuances, and hibernation appears not on dockets but in disclosure statements and plans, so these sections reflect data from 42 of the hospitals. (Plans and disclosure statements were unavailable in 14 of the cases.)

151. Plan at 13, *In re Watonga Hosp. Tr. Auth.*, No. 04-10415 (Bankr. W.D. Okla. Mar. 21, 2006), ECF No. 67.

152. Disclosure Statement at 5-6, *In re Adair Cnty. Hosp. Dist.*, No. 13-10940 (Bankr. W.D. Ky. Dec. 18, 2015), ECF No. 316 (noting the tax and voter resistance).

153. Disclosure Statement at 15, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 313.

154. Kevin Jenkins, *County Hospital Makes Strides*, DAILY J. ONLINE (Sept. 11, 2018), <https://dailyjournalonline.com/2018/09/11/county-hospital-makes-strides> [<https://perma.cc/M5UM-659K>].

155. Ryan E. Manns & Scott Kortmeyer, *Texas Hospital District Emerges from Bankruptcy Through Innovative Restructuring*, NORTON ROSE FULBRIGHT (Apr. 2019), <https://www.nortonrosefulbright.com/en-us/knowledge/publications/a4ee9e37/texas-hospital-district-emerges-from-bankruptcy-through-innovative-restructuring> [<https://perma.cc/4W3S-R5ST>].

156. CLIFTONLARSONALLEN LLP, GAINESVILLE HOSPITAL DISTRICT FINANCIAL STATEMENTS: YEARS ENDED SEPTEMBER 30, 2020 AND 2019, at 11 (Jan. 25, 2021) [<https://perma.cc/YR7X-NTTH>].

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Likewise, Pauls Valley Hospital,¹⁵⁷ East Shoshone Hospital,¹⁵⁸ and Palm Drive Hospital¹⁵⁹ all issued bonds to cover prebankruptcy debt and the expenses of their bankruptcies.

Hibernation. Another, albeit rarer, option for private debtors is hibernation. This phenomenon, noted by Ronald Mann in the tech-startup context, can arise when the business's technology works but is not in current demand.¹⁶⁰ So the business shuts down, laying off employees. But it does not file for bankruptcy, instead opting to wait for better market conditions to return to profitability.

Public hospitals hibernate too, and with some frequency, but often do so *in bankruptcy*. Hall County Hospital, Chambers County Hospital, Southern Inyo Hospital (2016), Alta Hospital, Tulare Hospital, Coalinga Regional Medical Center, Palm Drive Hospital, Bamberg County Hospital, Pauls Valley Hospital, and Adair County Hospital all closed (in whole or in part) for a time during bankruptcy.¹⁶¹

The typical hibernation scenario involves a hospital closing temporarily during its bankruptcy and then reopening once its finances are sorted out, either through a reorganization or a sale. For example, Coalinga

157. Disclosure Statement at 15, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 313. Southern Inyo in its 2016 bankruptcy sought to issue revenue bonds, but the measure failed California's two-thirds requirement. See Disclosure Statement at 66, *In re S. Inyo Healthcare Dist.*, No. 16-10015 (Bankr. E.D. Cal. Mar. 12, 2020), ECF No. 908; Deb Murphy, *SIHD Board Dealing with Failure of Measure J*, SIERRA WAVE MEDIA (Apr. 25, 2018) <https://sierrawave.net/sihd-board-dealing-with-failure-of-measure-j> [<https://perma.cc/DH5L-GY7A>].

158. Disclosure Statement at 5, *In re E. Shoshone Hosp. Dist.*, No. 00-20980 (Bankr. D. Idaho Oct. 6, 2000), ECF No. 21.

159. David Abbott, *Palm Drive Exits Bankruptcy*, SOCoNEWS (May 12, 2011), https://www.soconews.org/sonoma_west_times_and_news/news/palm-drive-exits-bankruptcy/article_f372d365-466e-55ec-952f-abf962cdd43b.html [<https://perma.cc/XZ2Y-G6NL>].

160. Ronald J. Mann, *An Empirical Investigation of Liquidation Choices of Failed High Tech Firms*, 82 WASH. U. L.Q. 1375, 1381 & n.16 (2004).

161. Disclosure Statement at 19, *In re Hall Cnty. Hosp. Dist.*, No. 01-21283 (Bankr. N.D. Tex. Aug. 26, 2002); Disclosure Statement at 19, *In re S. Inyo Healthcare Dist.*, No. 16-1015 (E.D. Cal. Mar. 12, 2020); Disclosure Statement at 2, *In re Alta Healthcare Dist.*, No. 01-17857 (E.D. Cal. May 25, 2004), ECF No. 406; Ayla Ellison, *California Hospital Set to Emerge from Bankruptcy After 2 Years*, BECKER'S HOSP. REV. (Aug. 22, 2019) (Tulare), <https://www.beckershospitalreview.com/finance/california-hospital-set-to-emerge-from-bankruptcy-after-2-years.html> [<https://perma.cc/2883-YTFD>]; Disclosure Statement at 13, *In re Coalinga Reg'l Med. Ctr.*, No. 18-13677 (E.D. Cal. Nov. 25, 2019); Disclosure Statement at 34, *In re Palm Drive Health Care Dist.*, No. 14-10510 (N.D. Cal. March 15, 2019), ECF No. 481; *Bamberg County Hospital in South Carolina to Cease Inpatient Services*, BECKER'S HOSP. REV. (May 2, 2012), <https://www.beckershospitalreview.com/finance/bamberg-county-hospital-in-south-carolina-to-cease-inpatient-services.html> [<https://perma.cc/FJ8V-WE74>]; Barry Porterfield, *Day, Time Set for PV Hospital to Reopen*, PAULS VALLEY DEMOCRAT (Apr. 26, 2021), https://www.paulsvalleydailydemocrat.com/news/local_news/day-time-set-for-pv-hospital-to-open/article_be90be7a-5f08-5466-ac78-a34e372864f8.html [<https://perma.cc/RJQ6-KGCW>]; Ayla Ellison, *Bankrupt Kentucky Hospital Gets Lifeline After Halting Inpatient Services*, BECKER'S HOSP. REV. (Feb. 19, 2016), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/bankrupt-kentucky-hospital-gets-lifeline-after-halting-inpatient-services.html> [<https://perma.cc/K4X9-LPX9>].

Regional Medical Center (in its 2018 bankruptcy) ran out of cash to pay its staff and ceased providing services in June 2018.¹⁶² It filed for bankruptcy the next month.¹⁶³ After two years of sorting out its finances, the hospital reached an agreement for a management company to lease and operate the hospital and confirmed a plan in May 2020.¹⁶⁴ It reopened seven months later.¹⁶⁵

Hibernation makes financial sense for public hospitals. A public hospital, unlike most private corporations, generates revenue when it ceases to conduct business. It has no (or few) costs and collects taxes. So that temporary closure can give the hospital a boost in reorganizing.¹⁶⁶

In short, public hospitals have a variety of mechanisms to fund themselves both during a bankruptcy and looking forward. Like corporations, they may turn to DIP finance, though that is relatively infrequent and likely unattractive to lenders. Conversely, unlike corporations, public hospitals may raise taxes or issue bonds, and often couple that with hibernation, giving the hospital some extra cash and the runway needed to plan an exit strategy from bankruptcy.

D. Exiting Bankruptcy

Exiting bankruptcy, public hospitals seek to find stable footing going forward. To do so, they have two options. Either they can reorganize, staying public and having the district continue running operations. Or they can privatize, selling the hospital to a private business to operate the hospital.

The more common plan is reorganization. Of the 42 plans, two-thirds were formally reorganizations, with the plan having the hospital retain its assets.¹⁶⁷

162. Disclosure Statement at 12, *In re Coalinga Reg'l Med. Ctr.*, No. 18-13677 (Bankr. E.D. Cal. Dec. 3, 2019), ECF No. 471.

163. *Id.* at 13.

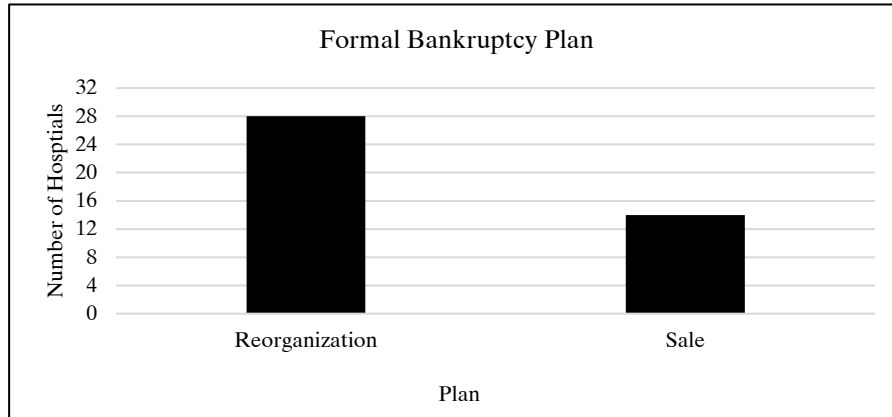
164. Order Confirming Plan, *In re Coalinga Reg'l Med. Ctr.*, No. 18-13677 (Bankr. E.D. Cal. May 29, 2020), ECF No. 582.

165. Mary Blyth Jones, *Coalinga Hospital Reopening Thursday*, COALINGA PRESS (Dec. 2, 2020), <https://coalingapress.org/2020/12/02/coalinga-hospital-reopening-thursday> [<https://perma.cc/WG53-TUSA>].

166. Despite its suitability for public hospitals, hibernation is unlikely to be a general phenomenon for other government bankruptcies. Cities, for example, cannot just temporarily cease to provide police protection. Counties must still run elections. And other special-purpose districts, like water districts, often provide services that cannot be temporarily stopped without the population leaving.

167. App. D (Plans). One of the plans, Whitney Hospital's, is a reorganization in name only. The hospital did nothing in its bankruptcy and filed a (mostly incomplete) plan when prompted by a show cause order. I have included it because the plan technically called for a reorganization, even though in reality it had little possibility of succeeding. Plan at 2, 19, 20, *In re Whitney Hosp. Auth.*, No. 01-60808 (W.D. Tex. 2001), ECF No. 74.

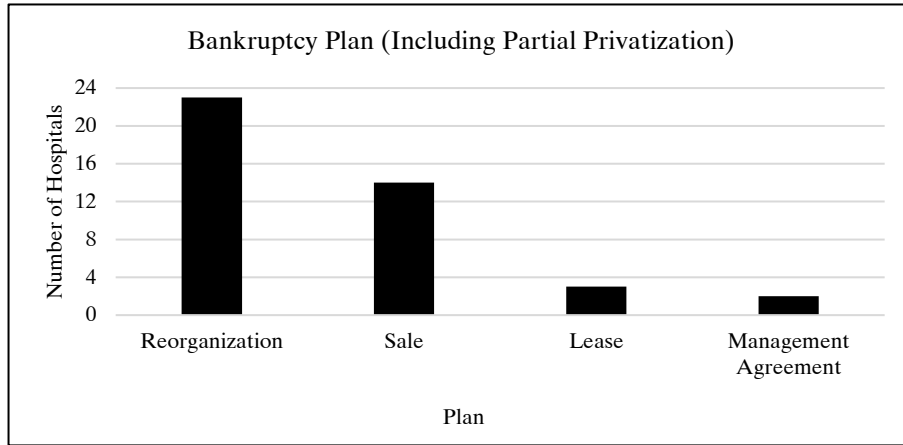
Figure 6



But a deeper dive reveals more privatization. Many formal reorganizations are partial privatizations. Some hospitals hire a private management company to operate the hospital, and others lease themselves to a private company to operate them. With these forms of partial privatization included, a fuller picture reveals that just over half (23 of 42) of public hospitals stay public by the end of bankruptcy.¹⁶⁸

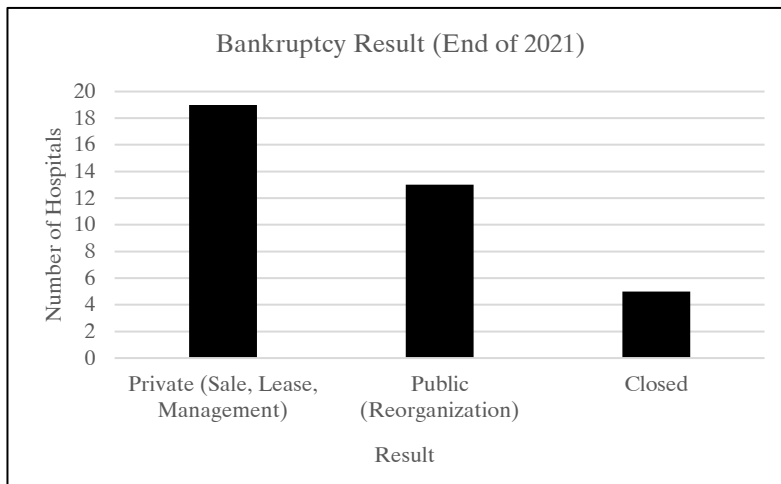
168. *Id.*

Figure 7



The trend toward privatization is more pronounced a few years after hospitals exit bankruptcy. A public hospital might emerge from bankruptcy as a public entity but later seek privatization in whole or in part. That can happen if the hospital’s initial aim in bankruptcy was privatization, but the privatization fell through during the bankruptcy. A picture, at the close of 2021, of all the hospitals with plans available shows privatization, in some form, is the most common long-term outcome.¹⁶⁹

Figure 8



169. *Id.* There are only 37 hospitals included because five filed twice in the period. This eliminates double-counting as to final outcome.

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Some of this privatization reflects trends over time as well. Before 2010, 14 of 22 cases were reorganizations.¹⁷⁰ After 2010, only 8 of 20 were.¹⁷¹ This trend suggests that changes in policy have disproportionately harmed public hospitals compared to private ones.¹⁷²

1. Reorganization

The public-hospital reorganization cases look a lot like ordinary business cases. Typically, the hospital needs to increase its revenues or correct a bad business decision. Once it does so, it can reemerge on stable footing as a public entity.

Increasing Revenue. One thing public hospitals do to reorganize is find new sources of revenue. Because the revenue sources are predominantly from reimbursements and secondarily from taxes, those are the natural levers to pull.

One key lever for increasing reimbursements is obtaining a “critical access hospital” designation under Medicare. That designation is available only for hospitals that are rural, maintain fewer than 25 beds, are 35 miles (or more) from another hospital, maintain 24/7 emergency services, and have an average stay length under four days.¹⁷³ With that designation, hospitals’ Medicare reimbursements are increased to more than the cost of providing services. So, instead of receiving eighty to ninety cents on the dollar under Medicare,¹⁷⁴ critical access hospitals receive 101 cents on the dollar for most Medicare reimbursements.¹⁷⁵ That allows some hospitals to stabilize their finances going forward.

The designation helped Chambers County Hospital, which filed for bankruptcy in 2000. Chambers attributed its financial issues to poor budgetary management and reduced Medicare and Medicaid reimbursements (likely an allusion to the Balanced Budget Act).¹⁷⁶ Chambers used the bankruptcy to streamline billing and collections, and to obtain a critical access designation.¹⁷⁷ It confirmed a plan in October 2003 and, as of a 2020 audit, remains on sound fiscal footing.¹⁷⁸

170. App. D (Plans)

171. *Id.*

172. *See infra* Section III.B (discussing the advantages of private hospitals that make sales attractive).

173. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 161 (2005).

174. Rose & Winthrop, *supra* note 6, at 193 n.21.

175. MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 173, at 160, 174 (noting that the critical-access-hospital designation helps low-volume hospitals).

176. Disclosure Statement at 16, *In re* Chambers Cnty. Hosp. Dist. No. 1, No. 00-80240 (Bankr. S.D. Tex. July 1, 2003), ECF No. 109.

177. *Id.* at 17.

178. DURBIN & CO. LLP, INDEPENDENT AUDITOR’S REPORT A-1 (2020) [<https://perma.cc/9J5S-LLKA>].

Hall County Hospital's 2001 bankruptcy was similar. There, too, collections were a problem, and the hospital was "very dependent on Medicare."¹⁷⁹ Like Chambers County Hospital, this hospital obtained the critical-access designation during its bankruptcy.¹⁸⁰ It confirmed a plan in 2002, which entailed reorganizing and downsizing to maintain a community clinic.¹⁸¹

In the same vein, public hospitals can increase revenue if voters support higher taxes to fund the hospital. Reorganizations are no exception, with hospitals like Pauls Valley Hospital and Iron County Hospital relying on new taxes, approved during the bankruptcy, to stabilize.¹⁸² Iron County Hospital confirmed its plan in March 2020, and its financials at the time revealed a return to positive cash flow.¹⁸³ Pauls Valley Hospital too is up and running again.¹⁸⁴

Business Corrections. As in corporate bankruptcy, some public hospital reorganizations center on correcting business mistakes. In Hardeman County Hospital's bankruptcy, for example, the hospital closed an unprofitable imaging center that it had leased 300 miles away.¹⁸⁵ The hospital also transferred three unprofitable rural health clinics to other providers.¹⁸⁶

Tri-City Mental Health Center is another helpful illustration. The hospital was formed in 1960, providing services to Pomona, Claremont, and La Verne, California.¹⁸⁷ In the 1990s, it expanded further into the

179. Disclosure Statement at 18, *In re Hall Cnty. Hosp. Dist.*, No. 01-21283 (Bankr. N.D. Tex. Aug. 28, 2002), ECF No. 54.

180. *Id.*

181. *Id.* at 19-20; Order Confirming Plan, *In re Hall Cnty. Hosp. Dist.*, No. 01-21283 (Bankr. N.D. Tex. Oct. 28, 2002), ECF No. 84. Other hospitals received the designation before bankruptcy, though often when they already encountered financial distress. *See, e.g.*, Disclosure Statement at 3, *In re Lost Rivers Dist. Hosp.*, No. 10-40344 (Bankr. D. Idaho Dec. 9, 2010), ECF No. 61 (receiving designation before bankruptcy and noting that it helped stabilize finances); Disclosure Statement at 3, *In re Hardeman Cnty. Hosp. Dist.*, No. 13-70103, (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288; Disclosure Statement at 8, *In re Mendocino Coast Health Care Dist.*, No. 12-12753 (Bankr. N.D. Cal. Dec. 15, 2014), ECF No. 162; Disclosure Statement at 3-4, *In re S. Inyo Healthcare Dist.*, No. 99-16515 (Bankr. E.D. Cal. Feb. 6, 2003), ECF No. 172. The designation is not a panacea, though. Southern Inyo Hospital, for example, filed for bankruptcy 17 years after its first filing despite the designation, and Hall County Hospital eventually closed.

182. Disclosure Statement at 15, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 313; Disclosure Statement at 20, *In re Iron Cnty. Hosp.*, No. 18-10111 (Bankr. E.D. Mo. Dec. 9, 2019), ECF No. 249.

183. *Balance Sheet*, IRON CNTY. MED. CTR. (Apr. 30, 2020) [<https://perma.cc/H6GJ-TV5P>].

184. Barry Mangold, *Pauls Valley Hospital Opens Under New Ownership*, (May 3, 2021), <https://www.news9.com/story/6090cdf15f19570dc71f5ea2/pauls-valley-hospital-opens-under-new-ownership.html> [<https://perma.cc/TMP3-NY23>].

185. Disclosure Statement at 16, 28, *In re Hardeman Cnty. Hosp. Dist.*, No. 13-70103, (Bankr. N.D. Tex. Sept. 15, 2015), ECF No. 288.

186. *Id.* at 27-28.

187. Disclosure Statement at 15, *In re Tri-City Mental Health Ctr.*, No. 04-13167 (Bankr. C.D. Cal. Dec. 11, 2006), ECF No. 192.

surrounding areas, but the expansion proved unsustainable.¹⁸⁸ So the hospital used bankruptcy to retrench, closing five facilities and consolidating into one facility in Pomona, keeping with a model that it had found sustainable for three decades.¹⁸⁹

Chapter 18s. One possible concern is that hospitals overuse bankruptcy, turning to bankruptcy when it cannot fix their problems. If it had merit, that concern would manifest in hospitals quickly returning to bankruptcy, a well-known result in business bankruptcy. In the business-bankruptcy context, scholars have referred to such returns as “Chapter 22,” that is, a Chapter 11 bankruptcy followed by another Chapter 11 filing.¹⁹⁰ Hence, I will refer to a repeat Chapter 9 bankruptcy as a “Chapter 18” filing, with a repeat filing suggesting that the initial filing may have been a misuse of the bankruptcy system.

The seven hospitals that filed Chapter 18s are too small a sample for quantitative work. But qualitatively, public hospitals do not generally appear to be misusing bankruptcy. In the paragraphs that follow, I examine each of the seven Chapter 18 filings and conclude that, although the reasons for refiling are varied, they do not appear to stem from a failure of or widespread abuse of Chapter 9.

Indian Valley Hospital (1991, 2003). The information on Indian Valley’s bankruptcies is sparse. The files for the 1991 bankruptcy have been destroyed, and it appears that the district languished in bankruptcy until 2000.¹⁹¹ Three years later, it refiled thanks to a host of problems—reductions in reimbursements, deferred maintenance, management turnover, and regulatory burdens it could not meet.¹⁹² The 2003 case floundered as well, and after efforts to make the hospital sustainable failed, the district voluntarily dismissed its own case, unable to even pay administrative expenses.¹⁹³ So it is unlikely that the 2000 exit from bankruptcy had much chance of success (and thus the 1991 filing was an improper use of bankruptcy), but the lack of information makes it hard to definitively label this case an improper use of Chapter 9.

Southern Inyo County Hospital (1999, 2016). Southern Inyo County Hospital was a rural hospital with few prospects in its first bankruptcy. Yet it confirmed a plan in March 2003 and its first case closed in April

188. *Id.* at 16, 21.

189. *Id.* at 21-22; *see also* Disclosure Statement at 19-20, *In re* Hall Cnty. Hosp. Dist., No. 01-21283 (Bankr. N.D. Tex. Aug. 28, 2002), ECF No. 54 (downsizing).

190. *See* Edward I. Altman, *Revisiting the Recidivism – Chapter 22 Phenomenon in the U.S. Bankruptcy System*, 8 BROOK. J. CORP. FIN. & COM. L. 253, 253 (2014).

191. Rose & Winthrop, *supra* note 6, at 207.

192. *Id.*

193. *See* Status Conference Statement, *In re* Indian Valley Healthcare Dist., No. 03-32839 (Bankr. E.D. Cal. July 9, 2012), ECF No. 187; Civil Minute Order, *In re* Indian Valley Healthcare Dist., No. 03-32839 (Bankr. E.D. Cal. July 9, 2012), ECF No. 197.

2007.¹⁹⁴ In the following years, it struggled with the usual challenges for rural public hospitals—difficulties recruiting personnel, a patient mix with little private insurance, an inability to pay for maintenance and improvements, and payment reductions.¹⁹⁵ It did, however, stay afloat for quite some time, likely thanks to a critical-access-hospital designation from Medicare, and it appears that its return to bankruptcy in 2016 (thirteen years after confirming its first plan) was not a foregone conclusion given the additional revenue stream.¹⁹⁶

Coalinga Regional Medical Center (2003, 2018). The first Coalinga bankruptcy seems to have had a range of causes. Reductions in reimbursements (presumably from the Balanced Budget Act) along with regulatory requirements, deferred maintenance, management turnover, and difficulty attracting staff all played a role.¹⁹⁷ At the same time, the district anticipated population growth, solved its turnover problems, and found new sources of state and federal funding during the bankruptcy, suggesting that it could stabilize.¹⁹⁸ And it confirmed a plan of reorganization in one year, further bolstering the argument that bankruptcy was proper for the hospital.¹⁹⁹ The 2018 disclosure statement indicates that a *new* round of cost reductions and regulatory requirements caused the follow-on bankruptcy,²⁰⁰ so there was reason to believe that the hospital would be sustainable after the first bankruptcy and therefore that it was not abusing Chapter 9.

West Contra Costa County Hospital (2006, 2016). This bankruptcy was likely an improper use of Chapter 9 reorganization. Before its first bankruptcy, the hospital was not profitable and ultimately hired Tenet Healthcare Corporation to manage the hospital.²⁰¹ Tenet terminated the management agreement in 2004, and the hospital returned to hemorrhaging money—before filing in 2006, it had lost \$29.7 million that year.²⁰² It did confirm a plan in 2008, but the plan called for a bond issuance of \$26 million that the hospital could not sustain.²⁰³ So the 2006 use of Chapter 9 was probably too optimistic—the hospital did not appear to have a route to a viable reorganization.

194. App. A (Dockets).

195. Disclosure Statement at 2-6, *In re* S. Inyo Healthcare Dist., No. 99-16515 (Bankr. E.D. Cal. Feb. 6, 2003), ECF No. 172.

196. Rose & Winthrop, *supra* note 6, at 216-18.

197. Disclosure Statement at 3-4, *In re* Coalinga Reg'l Med. Ctr., No. 03-14147 (Bankr. E.D. Cal. Apr. 26, 2004), ECF No. 144.

198. *Id.* at 5, 9-11.

199. Rose & Winthrop, *supra* note 6, at 220-22.

200. Disclosure Statement at 11, *In re* Coalinga Reg'l Med. Ctr., No. 18-13677 (Bankr. E.D. Cal. Dec. 3, 2019), ECF No. 471.

201. Rose & Winthrop, *supra* note 6, at 200-01.

202. *Id.* at 201.

203. Disclosure Statement at 7-8, *In re* W. Contra Costa Cnty. Healthcare Dist., No. 16-42917 (Bankr. N.D. Cal. Aug. 3, 2017), ECF No. 146.

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Palm Drive Hospital (2007, 2014). The hospital's 2007 bankruptcy too was likely an improper use of Chapter 9. In that bankruptcy, given its patient mix and reimbursement rates, the hospital's finances simply did not add up. To exit that 2007 bankruptcy, the Palm Drive Hospital District issued bonds, with the aim of paying off the old bankruptcy's debts.²⁰⁴ But there was insufficient cash flow to pay the bonds and so the hospital found itself refiling for bankruptcy in 2014 again—just one month after it closed its first bankruptcy case.²⁰⁵

Natchez Regional Medical Center (2009, 2014). Natchez blamed its first bankruptcy, in large part, on poor management, going so far as to sue Quorum, the private business it hired to run the hospital.²⁰⁶ Indeed, the 2009 filings are optimistic, describing the “very significant opportunity” for growth in market share, population growth, and ability to attract talented physicians.²⁰⁷ So Natchez's initial use of Chapter 9 made sense, as the problems seemed to have been corrected by firing bad management. That said, the optimism was misplaced, and the 2014 filings reveal that even with a change of management, the hospital was not fiscally sound. Those filings acknowledged the hospital's difficulty in recruiting physicians, an associated decline in patient volume, and then an inability to make necessary capital improvements.²⁰⁸

Jack County Hospital (2020, 2020). The Jack County Hospital refiling is a refiling only in the most technical sense. In October 2019, the hospital lost a \$30 million arbitration with Blue Cross Blue Shield.²⁰⁹ The hospital could not pay, so it filed for bankruptcy in February 2020.²¹⁰ Not long after, Congress approved funding for small businesses amid the pandemic, but the Small Business Authority made that funding available to hospitals on the condition that they not be in bankruptcy.²¹¹ So, the hospital dismissed its first bankruptcy, applied for funding, received funding, and refiled for bankruptcy in June 2020.²¹²

Overall, then, reorganization tends to work for public hospitals, especially when hospitals have more revenue available (through a critical access designation or new taxes) or can correct one-off business mistakes.

204. Disclosure Statement at 16-19, Ex. D (Statement of Operations) at 2, *In re Palm Drive Health Care Dist.*, No. 14-10510 (Bankr. N.D. Cal. Mar. 15, 2019), ECF No. 481.

205. App. A (Dockets).

206. Disclosure Statement at 1, *In re Natchez Reg'l Med. Ctr.*, No. 09-00477 (Bankr. S.D. Miss. Feb. 12, 2009), ECF No. 18.

207. *Id.* at 2, 5, 8-10.

208. Disclosure Statement at 23-24, *In re Natchez Reg'l Med. Ctr.*, No. 14-01048 (Bankr. S.D. Miss. Aug. 29, 2014), ECF No. 410.

209. Disclosure Statement at 14, *In re Jack Cnty. Hosp. Dist.*, No. 20-42012, (Bankr. N.D. Tex. Nov. 23, 2020), ECF No. 61.

210. *Id.*

211. *Id.* at 15.

212. *Id.* at 15-16.

Indeed, the record suggests that hospitals are not abusing Chapter 9 bankruptcy; rather, they are emerging and surviving.

2. Sales

The primary alternative to reorganization is a sale—that is, full privatization. The rise of sales mirrors developments in corporate bankruptcy. But here, too, public hospitals differ from their corporate counterparts.

For starters, sales gained popularity among public hospitals in the 2010s, lagging corporate bankruptcy by a decade. In these sales, a private buyer purchases the assets of the hospital from the hospital district and provides the same (or similar) services as the district did. Often, the sale terms require as much, or at least require that the buyer use those assets to provide healthcare.²¹³ That differs from corporate sales, where there is no concern that a community continue to receive specific services.

After such a sale, public hospital districts also differ sharply from corporations sold in bankruptcy. Critically, the hospital district does not dissolve after a sale. Instead, after a private buyer receives the hospital's assets, the hospital district continues to exist. It operates as a shell of its former self (with no assets) but retains its authority to tax.

Often, that taxation is part of the bankruptcy plan and is used to repay creditors. For instance, East Shoshone Hospital knew that its hospital was unsustainable—a rural district with two hospitals usually is.²¹⁴ So it planned to close the hospital and sell the district's assets, then issue bonds to repay creditors and have the district exist solely to tax residents to fund the bonds.²¹⁵

Sometimes, shell districts levy taxes to provide complementary health services. Alta's shell district, for example, paid off its final debts in 2015 and makes grants for various health projects in the district now that it no longer operates a hospital.²¹⁶ Sierra Kings's shell district also gives grants to local community health projects now that it has repaid its credi-

213. *E.g.*, Motion for an Order Authorizing a Substitute Asset Purchase Agreement, Ex. A (Asset Purchase Agreement) at 32-33, *In re Barnwell Cnty. Hosp.* (Dec. 7, 2012), ECF No. 280-1 (showing a covenant to “carry on the Business in substantially the same manner” with hospital assets).

214. Disclosure Statement at 2, *In re E. Shoshone Hosp. Dist.*, No. 00-20980 (Bankr. D. Idaho Oct. 6, 2000), ECF No. 21.

215. *Id.* at 5-6. East Shoshone Hospital District was dissolved in 2015. *Around Idaho: May Economic Activity*, IDAHO DEP'T OF LAB. (June 2, 2015), <https://idahoatwork.com/2015/06/02/around-idaho-may-economic-activity> [<https://perma.cc/DR34-VS6Q>].

216. *History*, ALTA HEALTHCARE DIST., <https://www.altahcd.com/history> [<https://perma.cc/F8UB-7QUA>]; *Grants*, ALTA HEALTHCARE DIST., <https://www.altahcd.com/grants> [<https://perma.cc/MA77-JWLE>].

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tors.²¹⁷ Kennewick's district too collaborates with other providers in the area and, through the district itself, offers adult day services.²¹⁸

But, in the long term, these shell districts often tax the community without providing much in return.²¹⁹ And the districts can be quite challenging to shut down. Los Medanos Hospital, for instance, filed for bankruptcy in 1994 and attempted to sell its hospital.²²⁰ When the sale fell through, the district leased the hospital to Contra Costa County to run a health clinic.²²¹ But the district persisted until 2022, taxing residents until it was finally dissolved after decades of inefficient grantmaking and excessive administrative costs.²²²

Repeat Bankruptcies and Winding Up. As for the hospitals themselves, sales do not result in more closures than reorganizations do. Of the hospitals with plans contemplating a sale, only Alta Hospital, East Shoshone Hospital, and West Contra Costa County Hospital (2016) resulted in a hospital closing by the end of the sample period. Of those, East Shoshone Hospital was unsustainable before the bankruptcy and used the bankruptcy to wind down the hospital, so the sale there was a liquidation rather than a failed attempt to keep the hospital alive. West Contra Costa County Hospital was similar, having emerged from its first bankruptcy (a reorganization) without a viable path forward.

The use of sales in Chapter 9, therefore, generally succeeds at maintaining healthcare in the community. And when it does not succeed, the

217. *History of the District*, SIERRA KINGS HEALTH CARE DIST., <https://skhcd.org/our-history> [<https://perma.cc/QE6Q-KXMK>].

218. Leland B. Kerr, *Kennewick Public Hospital District Remains a Critical Part of Our Community's Healthcare System*, KENNEWICK PUB. HOSP. DIST. 3 (2022), <https://kenphd.com/downloads> [<https://perma.cc/C8CT-N7TH>].

219. For example, it is not clear what West Contra Costa County Healthcare District or Natchez Regional Medical Center's district *do* now that they no longer operate a hospital.

220. *Los Medanos: County Will Convert Hospital to Outpatient Clinic*, CAL. HEALTHLINE (Feb. 26, 1998), <https://californiahealthline.org/morning-breakout/los-medanos-county-will-convert-hospital-to-outpatient-clinic-endstoryhed> [<https://perma.cc/W6QH-YH2M>].

221. *Id.*

222. Ron Tervelt, "*Lost*" *Medanos Community Health Care District: Awash in a Sea of Inefficiency*, CONTRA COSTA CNTY. CIV. GRAND JURY 1 (2010), <https://www.cc-courts.org/civil/docs/grandjury/rpt1009.pdf> [<https://perma.cc/357E-J56F>]; *State Assembly Passes Frazier Bill to Dissolve Los Medanos Community Healthcare District*, E. CNTY. TODAY (May 12, 2021), <https://eastcountytoday.net/state-assembly-passes-frazier-bill-to-dissolve-los-medanos-community-healthcare-district> [<https://perma.cc/9TKC-J96W>]. Likewise, Palm Drive Health Care District dissolved in 2020, 13 years after its first bankruptcy and 6 years after its second. See Laura Hagar Rush, *LAFCO Dissolves the Palm Drive Health Care District*, SOCONEWS (Aug. 8, 2020), https://www.soconews.org/sonoma_west_times_and_news/news/lafco-dissolves-the-palm-drive-health-care-district/article_74b1fe4c-d9e6-11ea-908f-db83b6c337cf.html [<https://perma.cc/22TK-9FCS>]. Upon dissolution, district assets and liabilities are transferred to the county. For an explanation of this phenomenon in California, see Marc Joffe, *West Contra Costa Healthcare District Goes Bankrupt Again; Time to Throw in the Towel*, CAL. POL'Y CTR. (Oct. 31, 2016), <https://californiapolicycenter.org/west-contra-costa-healthcare-district-goes-bankrupt-time-throw-towel> [<https://perma.cc/G9T8-VEWF>] (labeling these "zombie public hospital districts").

community often recognizes that the hospital is unsustainable and uses Chapter 9 to wind up the business rather than revitalize it.

3. Other

The hospitals that neither reorganize nor sell themselves have a variety of other outcomes. Of these, no consistent story emerges; they are simply one-offs. For completeness, this Section describes those outliers, though their oddity reinforces that public hospitals use bankruptcy much like businesses do—some reorganizations, some sales, and some bespoke arrangements based on unique situations.

Involuntary Dismissal. One such outcome is involuntary dismissal, which happened in the Charlton County Hospital bankruptcy. The hospital there served a rural Georgia county.²²³ When the hospital encountered distress in 2012, it filed for bankruptcy. But the Bankruptcy Code requires that states “specifically authorize[.]” a municipality to file.²²⁴ Georgia does not, which drew a motion to dismiss from the U.S. Trustee, the federal official charged with supervising bankruptcies.²²⁵ The issue was an easy one, and the court granted the Trustee’s two-page motion, dismissing the hospital’s petition.²²⁶ The hospital closed a few months later.²²⁷

Nonprosecution. A different dismissal happened in the Whitney Hospital bankruptcy. There, the hospital filed for bankruptcy but did not appear to do anything in bankruptcy, using bankruptcy as a shield from creditors rather than a reorganization tool. It did not, for instance, file the required disclosure statement.²²⁸ And its plan came only after a court show-cause order.²²⁹ Ultimately, the Internal Revenue Service and one of the lenders filed a motion to dismiss for nonprosecution,²³⁰ which the

223. *Charlton Memorial: 3rd Rural Georgia Hospital to Close This Year*, BECKER’S HOSP. REV. (Aug. 27, 2013), <https://www.beckershospitalreview.com/hospital-management-administration/charlton-memorial-3rd-rural-georgia-hospital-to-close-this-year.html> [<https://perma.cc/Q3VG-AJ2E>].

224. 11 U.S.C. § 109(c)(2) (2018).

225. Motion to Dismiss, *In re Hosp. Auth. of Charlton Cnty.*, No. 12-50305 (Bankr. S.D. Ga. May 3, 2012), ECF No. 6.

226. Order Dismissing Case, *In re Hosp. Auth. of Charlton Cnty.*, No. 12-50305 (Bankr. S.D. Ga. July 3, 2012), ECF No. 68.

227. See *Charlton Memorial: 3rd Rural Georgia Hospital to Close This Year*, *supra* note 223.

228. See Joinder of Lender in Motion to Dismiss at 2, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Jan. 8, 2004), ECF No. 91 (noting that the hospital did not file a disclosure statement with its Chapter 9 plan).

229. Show Cause Order, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Jan. 25, 2002), ECF No. 46; Plan, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Sept. 1, 2003), ECF No. 74.

230. Motion to Dismiss, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Dec. 23, 2003), ECF No. 90; Joinder of Lender in Motion to Dismiss, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Jan. 8, 2004), ECF No. 91.

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court granted.²³¹ In 2014, after a series of failed deals, the hospital closed.²³²

Avenal Hospital was another nonprosecution dismissal. There, though, the judge issued a show-cause order, and no creditor moved to dismiss.²³³ When Avenal Hospital's response was inadequate, he dismissed the bankruptcy.²³⁴

Failure. Another outcome is outright failure caused by the debtor's free fall. That happened only in Indian Valley Hospital's 2003 bankruptcy. There, the hospital had so few assets that it could not pay administrative expenses or priority claims designed to ensure that lawyers, for example, would be paid and thus work on the case.²³⁵ Without such assurances, the hospital's bankruptcy could not succeed, and it filed a voluntary motion to dismiss.²³⁶ Since the dismissal, the district appears to exist only on paper.²³⁷

Merger. One clever use of bankruptcy was by South Carolina, which used the bankruptcy court to merge two of its struggling public hospitals. In 2011, both Bamberg County Hospital and Barnwell County Hospital filed for bankruptcy.²³⁸ The solution for the hospitals was part sale (to a regional health provider) and part merger (of the facilities into one).²³⁹ That entailed the replacement of the Barnwell and Bamberg hospitals with a newly built hospital, with clinics for coverage in the interim.²⁴⁰ The

231. Order Dismissing Case, *In re Whitney Hosp. Auth.*, No. 01-60808 (Bankr. W.D. Tex. Apr. 20, 2004), ECF No. 115.

232. *Beleaguered Lake Whitney Medical Center Shuts Down*, BECKER'S HOSP. REV. (Apr. 3, 2014), <https://www.beckershospitalreview.com/hospital-management-administration/beleaguered-lake-whitney-medical-center-shuts-down.html> [<https://perma.cc/QCA4-6QR4>].

233. Response to Show Cause Order at 1, *In re Avenal Hosp. Dist.*, No. 93-15960 (Bankr. E.D. Cal. Aug. 23, 1999), ECF No. 33.

234. Order Dismissing Case, *In re Avenal Hosp. Dist.*, No. 93-15960 (Bankr. E.D. Cal. Oct. 5, 1999), ECF No. 36.

235. 11 U.S.C. §§ 503, 507 (2018).

236. See Status Conference Statement, *In re Indian Valley Healthcare Dist.*, No. 03-32839 (Bankr. E.D. Cal. July 9, 2012), ECF No. 187; Civil Minute Order, *In re Indian Valley Healthcare Dist.*, No. 03-32839 (Bankr. E.D. Cal. Sept. 24, 2012), ECF No. 197 (dismissing the case).

237. Rose & Winthrop, *supra* note 6, at 208.

238. Petition, *In re Bamberg Cnty. Mem'l Hosp.*, No. 11-03877 (Bankr. D.S.C. June 20, 2011), ECF No. 1; Petition, *In re Barnwell Cnty. Hosp.*, No. 11-06207 (Bankr. D.S.C. Oct. 5, 2011), ECF No. 1.

239. Associated Press, *Bamberg, Barnwell Counties to Get New Hospital*, POST & COURIER (Nov. 2, 2016), https://www.postandcourier.com/bamberg-barnwell-counties-to-get-new-hospital/article_e9414892-90d4-5f6e-a0b6-3d6d263142c8.html [<https://perma.cc/QLL2-QY52>]. Similarly, Natchez Regional Medical Center merged with Natchez Community Hospital (a nonprofit) after its bankruptcy. See Press Release, Natchez Cmty. Hosp., Natchez Hospitals to Combine Forces, Consolidate Operations (Oct. 1, 2014) [<https://perma.cc/W397-YD9S>].

240. Disclosure Statement at 1-2, *In re Barnwell Cnty. Hosp.*, No. 11-06207 (Bankr. D.S.C. Mar. 23, 2012), ECF No. 127.

new facility opened in 2019, offering emergency care and outpatient services.²⁴¹

These quirky outcomes should not detract from the main picture. Public hospitals enter bankruptcy and predominantly confirm a plan, in which they reorganize or privatize. In so doing, they typically return the hospital to viability and, in so doing, preserve healthcare in their communities.

4. Sales vs. Reorganization

Why Sales. In the 2000s, academics noted a shift in large corporate bankruptcies. Many were no longer reorganizations, but instead sales, where the corporate debtor would sell substantially all its assets using Section 363 of the Bankruptcy Code and then distribute the proceeds to creditors.²⁴² The plan would do little more than distribute the cash value of the assets, and then the debtor would dissolve. To give a sense of how pervasive these sales became, in 2002 (the high-water mark), this phenomenon occurred in 84% of large bankruptcies.²⁴³

Advocates of a law-and-economics approach, most notably Douglas Baird and Robert Rasmussen, to bankruptcy have long recognized that 363 sales were one logical endpoint of that theory of bankruptcy and an efficient solution.²⁴⁴ As they explained, it seldom matters whether assets belong to one business or another.²⁴⁵ A tractor, for example, has the same market value whether it is owned by Cabbage Corporation or Future Industries. So too for intangible property, like the value of groups of employees with specialized knowledge or skills. A law-firm practice group, say, is just as valuable at a Big Law firm or at a boutique firm so long as the group members stick together.

Sales, then, do not disrupt the value of a bankrupt business's assets. In fact, sales are the quintessential market mechanism in that they determine what the value of the assets *is*. Thus, instead of a judge speculating on value, the sale reduces a debtor to a pile of cash that *is* its value.²⁴⁶ In

241. Michael Fuller, *New Bamberg Hospital Will Make Medical Care More Accessible for Residents*, WLTX (Apr. 2, 2019), <https://www.wltx.com/article/news/local/new-hospital-opening-in-bamberg/101-e2bd7db0-1201-47ac-8520-f0bc42ac08ce> [<https://perma.cc/G8JU-RKG9>].

242. Douglas G. Baird & Robert K. Rasmussen, *The End of Bankruptcy*, 55 STAN. L. REV. 751, 751-52 (2002).

243. Douglas G. Baird & Robert K. Rasmussen, *Chapter 11 at Twilight*, 56 STAN. L. REV. 673, 674 (2003). In a more typical year, the percentage is lower, but still runs around 20% to 30% of resolutions of big bankruptcy cases. See Lynn M. LoPucki & Joseph W. Doherty, *Bankruptcy Fire Sales*, 106 MICH. L. REV. 1, 43 (2007).

244. See, e.g., Baird & Rasmussen, *supra* note 242, at 755-56.

245. *Id.* at 768-77.

246. See Douglas G. Baird, *The Uneasy Case for Corporate Reorganizations*, 15 J. LEGAL STUD. 127, 136-37 (1986).

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turn, creditors receive a payout (based on Code priorities) reflecting the actual value of the debtor and, thus, the actual value of their claims.

As a final point, sales can ease the process of reorganization. Businesses can lose value each day in bankruptcy, known as the “ice cube” phenomenon.²⁴⁷ And a business in bankruptcy usually requires some changes to its business model. If those changes happen in bankruptcy, the reorganization is subject to onerous bankruptcy rules, including monthly operating reports, court oversight of contracts, and regular objections.²⁴⁸ If the assets are sold, the buyer can reorganize, making the same changes outside of bankruptcy, without the burdens of bankruptcy that can hamper or delay needed changes.

That public hospitals use bankruptcy sales speaks to the efficiency of sales in many cases. Public hospitals try to save the community’s hospital. And the hospitals face no pressure to sell from a bankruptcy judge because federalism constrains the judge from deciding the course of the bankruptcy.²⁴⁹ The choice of sales, then, suggests that hospitals sell because it preserves the hospital when alternatives do not.

Two other reasons suggest that public hospital bankruptcies sales are efficient. Start with the time horizon. The main critique of bankruptcy sales is the fire-sale discount. In a hurry, there is insufficient time to seek out many bids or press for the highest price for assets. That happens in private bankruptcy because Section 363 allows for a sale early in the process. As Melissa Jacoby and Edward Janger found, the median time from filing to sale approval was 110 days; Lynn LoPucki and Joseph Doherty found the average time was 223 days.²⁵⁰ By contrast, Chapter 9 does not incorporate Section 363,²⁵¹ so sales of the hospital take place through a confirmed plan. And the timeline for confirming plans in a hospital bankruptcy is long.²⁵²

247. Melissa B. Jacoby & Edward J. Janger, *Ice Cube Bonds: Allocating the Price of Process in Chapter 11 Bankruptcy*, 123 YALE L.J. 862, 862 (2014).

248. See Michael A. Francus, *Designing Designer Bankruptcy*, 102 TEX. L. REV. 1206, 1229 (2024); Anthony J. Casey & Joshua C. Macey, *In Defense of Chapter 11 for Mass Torts*, 90 U. CHI. L. REV. 973, 988 (2023).

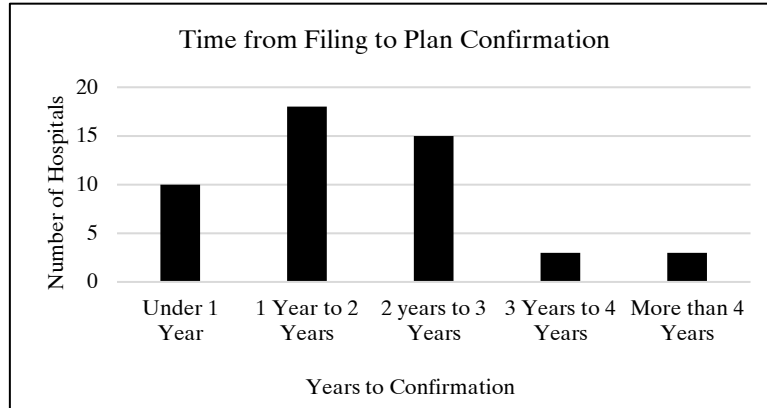
249. See 11 U.S.C. §§ 903-04 (2018).

250. Jacoby & Janger, *supra* note 247, at 879-80; LoPucki & Doherty, *supra* note 243, at 25.

251. See 11 U.S.C. § 901 (2018).

252. App. A (Dockets). For the subset of hospitals that use bankruptcy for a 363 sale, the numbers are similar, with the average time to plan confirmation being 689 days and only one (Natchez’s 2014 bankruptcy) of the fourteen reaching confirmation in under the 223 days that LoPucki and Doherty found as an average for corporate debtors’ 363 sales. *Id.*; App. D (Plans).

Figure 9



This longer time horizon likely results in higher sale prices. Anne Anderson and Yung-Yu Ma show as much for Chapter 11 sales, where the sale-through-a-plan model results in higher sale prices than 363 sales do.²⁵³ So, the public hospitals' taking their time suggests that they do not suffer a fire-sale discount.²⁵⁴

Public-hospital sales are also efficient because of the significance of the public/private divide. In a corporate bankruptcy, it does not matter if assets are owned by Hospital Corporation or Healthcare Corporation. But for *public* hospitals, it matters whether the assets are owned by a government hospital district or a private corporation. And using a bankruptcy sale to cross the public/private divide yields benefits for a hospital.

Here's why. Public hospital districts are limited in scope and geography to defined purposes and boundaries set by state law. They also have smaller budgets than regional or national hospital chains. Their leadership is typically elected, making them members of the community rather than experts in hospital management.²⁵⁵ So the private sector, when it comes to managing hospitals, benefits from economies of scale.²⁵⁶ It can

253. Anne M. Anderson & Yung-Yu Ma, *Acquisitions in Bankruptcy: 363 Sales Versus Plan Sales and the Existence of Fire Sales*, 22 AM. BANKR. INST. L. REV. 1, 3 (2014).

254. For example, Craig County Hospital spent a year deliberating before deciding to sell to Saint Francis Health System. See Alyssa Rege, *Saint Francis Health System to Purchase Oklahoma Hospital, Affiliated Clinics*, BECKER'S HOSP. REV. (Oct. 7, 2016), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/saint-francis-health-system-to-purchase-oklahoma-hospital-affiliated-clinics.html> [<https://perma.cc/4CCL-Z6H2>].

255. See, e.g., *Board of Directors*, COALINGA MED. CTR., <https://coalingamedicalcenter.com/about-us/board-of-directors> [<https://perma.cc/9GDE-WRLB>] (indicating that board members include an aerospace engineer, an office manager, and a president whose job experience is not listed).

256. Interestingly, hospitals that use management agreements instead of full privatization may not capture all these benefits. With a management agreement, the private management company does not capture all the upside of running the hospital well, because it receives the same fees. But with full privatization, a private business captures all the upside and

also pay management more and has the benefit of more expertise and resources.²⁵⁷ The result is that some hospitals cannot be sustained as public entities but can be sustained as private entities, and bankruptcy sales facilitate that transfer.

Why Reorganization. This does not mean, though, that sales are always the right answer for public hospitals. A private entity cannot tax, so public hospitals have a potential revenue source should they choose to reorganize. That means that a public hospital can reorganize if the tax revenue it receives suffices to counterbalance the disadvantages of public ownership. Alternatively, the public hospital may wish to subsidize services that are not otherwise cost-effective for private ownership, in which case the hospital has an independent reason to stay public so long as the taxpayers will fund those subsidies.

It makes sense, then, for public hospitals to reorganize when the hospital is sustainable as a public entity, when there is insufficient private interest to achieve privatization, or when the community wants to maintain a subsidy for particular kinds of unprofitable care.

II. Lessons for Government Bankruptcy

Looking at a new class of bankruptcies sheds light on some old discussions in the field of government bankruptcy. For one, public-hospital bankruptcies challenge the criticisms of Chapter 9 leveled by those who argue that Chapter 9 does not work for cities, counties, and other political subdivisions. Public hospitals, in fact, show that government bankruptcy need not be rancorous and ineffective, but can be amiable and successful. More importantly, public hospitals also suggest *when* government bankruptcy will be successful: namely, when there is a single focal point (a government business's finances) rather than many tradeoffs (a city's budget).

thus has an incentive to keep improving the hospital's bottom line, within the constraints of the sale covenants. This might explain why some public hospitals with prebankruptcy management agreements still found themselves in bankruptcy. *See supra* notes 89-96 and accompanying text (discussing Quorum's poor management of hospitals). The limited upside for management companies also suggests a role for incentives clauses in such management agreements to better align management's pay with achieving specific goals of the district.

257. The sale can impose conditions on the buyer to ensure that the hospital's services satisfy the community and that the buyer does not simply eliminate unprofitable services. *See, e.g.,* Laura Hagar Rush, *Health District Sells Hospital*, SoCoNEWS, (Dec. 5, 2019), https://www.soconeews.org/sonoma_west_times_and_news/news/health-district-sells-hospital/article_14bd4e1a-16cd-11ea-93af-8bfc40d17717.html [<https://perma.cc/BFU4-BCLJ>] (imposing a \$1.2 million fee on the buyer if it stops using assets for healthcare); Motion for an Order Authorizing a Substitute Asset Purchase Agreement, Ex. A (Asset Purchase Agreement) at 32-33, *In re Barnwell Cnty. Hosp.* (Dec. 7, 2012), ECF No. 280-1 (showing a covenant to "carry on the Business in substantially the same manner" with hospital assets).

A. Criticisms of Government Bankruptcy

Criticisms of Chapter 9 are manifold, but largely fit into three camps. The most prominent argues that, because of constraints imposed by constitutional federalism concerns, Chapter 9 cannot handle the political aspects of bankruptcy and thus dooms government debtors to the same political mess that drove them to bankruptcy. Another contends that Chapter 9 lacks clear, or even coherent, rules. Finally, another argues that Chapter 9's insolvency requirement delays governments from filing until it is too late, undercutting any value that earlier debt relief might have brought.

Managing Politics. Chapter 9, from its creation, has had to contend with a federalism problem. Fundamentally, the chapter grants a federal bankruptcy judge control over core aspects of state governance. As the Court has explained, local governments are “creatures of the State,”²⁵⁸ and thus control over a city (or county, state agency, school district, or the like) implicates constitutional federalism concerns.

The Court invalidated the first iteration of Chapter 9 on federalism grounds. There it wrote that the “sovereignty of the state essential to its proper functioning under the Federal Constitution cannot be surrendered” and that nothing in the Bankruptcy Clause permits Congress to “pass laws inconsistent with the idea of sovereignty.”²⁵⁹ Congress then re-drafted the chapter to pass constitutional muster.²⁶⁰

Ever since, Congress has included ample protections for state sovereignty. Today's Chapter 9, therefore, prohibits a bankruptcy judge from interfering with “political or governmental powers of the debtor,” “property or revenues of the debtor,” and “the debtor's use or enjoyment of any income-producing property.”²⁶¹ For good measure, the Chapter also includes a section titled “Reservation of State power to control municipalities.”²⁶²

Critics argue that these restrictions on bankruptcy courts stifle municipalities and prevent judges from achieving meaningful reorganizations. As McConnell and Picker note, “In most cases, chronic financial difficulty is a sign that ordinary political processes are not functioning properly.”²⁶³ This critique implies that the inability of the bankruptcy court to tinker with politics and governance proves fatal to an effective reorganization.

258. *Coleman v. Miller*, 307 U.S. 433, 441 (1939).

259. *Ashton v. Cameron Cnty. Water Improvement Dist. No. 1*, 298 U.S. 513, 531 (1936).

260. *See United States v. Bekins*, 304 U.S. 27, 49-52 (1938).

261. 11 U.S.C. § 904 (2018)

262. *Id.* § 903.

263. McConnell & Picker, *supra* note 21, at 472.

Skeel and Gillette expand on the point, offering a model of such distress. On their view, fiscal distress stems from political fragmentation—different government actors determine expenditures but are not forced to internalize costs.²⁶⁴ For example, a city councilwoman has an incentive to spend citywide taxes on projects in her district. When the whole city council does so, they authorize projects that exceed what the city’s residents would like to pay in taxes.²⁶⁵ The resulting fiscal crunch is thus a matter of governance, not just hard economic times, and requires a governance solution that Chapter 9 cannot offer.²⁶⁶

In the same vein, Omer Kimhi writes that bankruptcy does nothing to change “political fragmentation,” “the power of interest groups,” or “the incentives that promoted local spending and caused the bankruptcy to begin with.”²⁶⁷ Likewise, Laura Coordes explains that Chapter 9 cannot “resolve underlying political issues.”²⁶⁸ In fact, both Coordes and Kimhi go a step further, fretting that Chapter 9 can *hurt* debtors that file, as bankruptcy inflicts reputational harm (driving away residents and scaring creditors)²⁶⁹ and masks political problems as financial ones, only deepening those problems.²⁷⁰

Lack of Coherence. Another critique of Chapter 9 stems from its alleged incoherence. Chapter 9 borrows from Chapter 11, a chapter traditionally used for business reorganizations. Chapter 9 incorporates the general framework of a reorganization plan as the trajectory for the bankruptcy as well as specific provisions that shape the plan negotiations in Chapter 11.²⁷¹

Yet the aims of the chapters differ, and thus the rules of Chapter 11 do not graft well onto Chapter 9. As Coordes explains, “Chapter 11 exists to maximize the value of the entity using it; Chapter 9 exists so that a

264. Gillette & Skeel, *supra* note 27, at 1184-85.

265. See Barry R. Weingast, Kenneth A. Shepsle & Christopher Johnsen, *The Political Economy of Benefits and Costs: A Neoclassical Approach to Distributive Politics*, 89 J. POL. ECON. 642, 654 (1981).

266. Gillette & Skeel, *supra* note 27, at 1195. On their view, bankruptcy judges should (and constitutionally could) strong-arm municipalities into such governance reform by holding that a plan without such reform is not “feasible” and thus may not be confirmed. *Id.* at 1206. To date, though, bankruptcy judges have not done so.

267. Kimhi, *supra* note 22, at 381.

268. Coordes, *supra* note 23, at 333.

269. Kimhi, *supra* note 22, at 382.

270. See Coordes, *supra* note 23, at 333; see also Michelle Wilde Anderson, *Dissolving Cities*, 121 YALE L.J. 1364, 1385-86 (2012) (comparing dissolution and bankruptcy for cities and noting that bankruptcy cannot solve governance issues); Richard C. Schragger, *Democracy and Debt*, 121 YALE L.J. 860, 881 (2012) (arguing that bankruptcy “does not help cities grapple with their underlying economic woes”); Moringiello, *supra* note 26, at 409 (calling for state intervention to complement gaps in what Chapter 9 can accomplish); Samir D. Parikh, *A New Fulcrum Point for City Survival*, 57 WM. & MARY L. REV. 221, 243 (2015) (finding Chapter 9 ineffective because of the judge’s inability to reform governance).

271. 11 U.S.C. § 901 (2018) (incorporating various provisions of Chapter 11).

municipality may survive.”²⁷² For example, a business might be liquidated if it lacks going-concern value, but a city will not be liquidated and must continue providing basic services (like public safety) even if unprofitable.²⁷³

Juliet Moringiello raises similar concerns. As she notes, corporate bankruptcy rests on a foundation of property law: The bankruptcy filing creates an estate, that estate consists of property, that property may be sold, or more property recovered, and a liquidation or reorganization will redistribute property (terminating some property rights and granting others) at the end of the bankruptcy.²⁷⁴ But that property model misaligns with Chapter 9 bankruptcy, where there is no estate, creditors cannot attach assets, assets typically are not sold, and the debtor presumptively retains its property at the end of a case. The result is a world where even the most basic concepts of bankruptcy, like priority in creditor repayment, are hard to apply because the foundational idea of property means little in a Chapter 9 case.²⁷⁵

Relief Too Late. A final critique of Chapter 9 points to the high insolvency standard, which precludes debtors from filing until they are on the brink. Under Chapter 9, a debtor must prove cash-flow insolvency—that is, the debtor is not paying its debts as they are due.²⁷⁶ Courts have policed that requirement rigorously. For example, a court dismissed Bridgeport’s bankruptcy because the city could pay its bills as they came due for the upcoming fiscal year.²⁷⁷ That insolvency requirement differs from the rest of the Code, which contains no other gatekeeping provisions requiring debtor insolvency.²⁷⁸

The effect, as McConnell and Picker note, is for a distressed city to pile on yet more debt, deepening the crisis before it is eligible to file for bankruptcy.²⁷⁹ This is especially troubling if the aim is to preserve what

272. Coordes, *supra* note 23, at 342.

273. See Michelle Wilde Anderson, *The New Minimal Cities*, 123 YALE L.J. 1118, 1193-94 (2014).

274. Juliet M. Moringiello, *Decision-Making and the Shaky Property Foundations of Municipal Bankruptcy Law*, 12 BROOK. J. CORP. FIN. & COM. L. 5, 10-11 (2017).

275. *Id.* at 35-36; cf. C. Scott Pryor, *Municipal Bankruptcy: When Doing Less Is Doing Best*, 88 AM. BANKR. INST. L. REV. 85, 119 (2014) (noting this problem with the “best interests” test); Richard M. Hynes & Steven D. Walt, *Fair and Unfair Discrimination in Municipal Bankruptcy*, 37 CAMPBELL L. REV. 25, 27-28 (2015) (noting this problem with “unfair discrimination”).

276. 11 U.S.C. § 109(c)(3) (2018) (incorporating *id.* § 101(32) (defining “insolvent”).

277. *In re City of Bridgeport*, 129 B.R. 332, 338 (Bankr. D. Conn. 1991).

278. Instead, abuse of the bankruptcy system by a solvent debtor can be policed, if at all, under a more nebulous “good faith” standard. See, e.g., *In re Integrated Telecom Express, Inc.*, 384 F.3d 108, 123-24 (3d Cir. 2004).

279. McConnell & Picker, *supra* note 21, at 456-57. Echoing this argument, Skeel writes that the insolvency standard should be set at “in default” or “in danger of default.” David A. Skeel, Jr., *State Bankruptcy from the Ground Up*, in WHEN STATES GO BROKE: THE ORIGINS,

Vince Buccola calls “spatial economies”—the value of having resources or complementary people and activities in the same place.²⁸⁰ Such spatial economies vanish when a city encounters debt overhang (an excess of debt that precludes new investment, even in worthwhile projects) and thus underinvests in people, activities, and resources. The inability to file for bankruptcy until desperation, therefore, undercuts much of the value Chapter 9 can yield.²⁸¹

B. The Hospital Bankruptcy Counterexample

The story of public hospitals in bankruptcy belies these critiques. Public-hospital bankruptcies succeed on their own terms—effecting a debt restructuring and preserving the hospital—with minimal strife along the way. Politics does not preclude these results. Nor does the ill fit of Chapter 11’s model for Chapter 9 prevent effective reorganization. And the insolvency requirement, too, seems to place no meaningful hurdle in the way of these hospitals.²⁸²

Creditors and Politics in Public-Hospital Bankruptcies. Public hospital bankruptcies are notably free of political dysfunction. In fact, these reorganizations are almost amiable, with few creditors pulling levers—like motions to dismiss, objections, and adversary proceedings—to upend the bankruptcy or extract settlement value. That suggests the creditors are content with the political structures and the outcomes those structures lead to in bankruptcy; they do not seek to disrupt the process as political foes would. They also may view bankruptcy as the likeliest or easiest way to recover, given the lack of alternative creditor remedies, and thus may prefer to support the reorganization rather than hinder it.

Start with motions to dismiss. As Coordes notes, once a court holds a debtor eligible to proceed under Chapter 9, the Code affords creditors few tools to protect themselves.²⁸³ So for creditors who wish to nix a Chapter 9 bankruptcy, a motion to dismiss (arguing that the stringent eligibility criteria have not been met) is *the* key leverage point. In turn, a

CONTEXT, AND SOLUTIONS FOR THE AMERICAN STATES IN FISCAL CRISIS 191, 204-05 (Peter Conti-Brown & David A. Skeel, Jr. eds., 2012).

280. Buccola, *supra* note 25, at 833.

281. *Id.* at 864-65.

282. This is true for hospitals that *use* Chapter 9, as evidenced by their success rate in confirming plans and their limited closure rates. It is possible that the insolvency requirement has deterred some hospitals from filing because they do not think they can satisfy it, and that those hospitals later shutter. It is hard to know how many such hospitals exist as they would not file, need not state that their choice to avoid Chapter 9 owes to the insolvency requirement, and could close for reasons that cannot be remedied by Chapter 9.

283. Coordes, *supra* note 23, at 321. Motions to dismiss have a lower chance of success in Chapter 11 because the eligibility requirements are less stringent. There, courts primarily police eligibility through a “good faith” standard.

motion to dismiss is a good indicator of creditor pugnacity in a Chapter 9 bankruptcy.

Only eleven of the 55 public-hospital bankruptcies discussed in this Article saw a motion to dismiss.²⁸⁴ And even that overstates creditors' desires to terminate cases. Jack County Hospital, for example, voluntarily dismissed its own case in 2021 to become eligible for COVID funding.²⁸⁵ The motion to dismiss Charlton County Hospital's case came from the U.S. Trustee (a federal watchdog)—not creditors—on the ground that Georgia forbids its public hospitals to file.²⁸⁶ The judge, on his own, dismissed Avenal's case.²⁸⁷ Indian Valley Hospital moved to dismiss its own 2003 case as well, explaining that the hospital could not pay administrative expenses.²⁸⁸ So only seven of the 55 cases featured a creditor seeking dismissal. (Of those, only Whitney Hospital's was dismissed.²⁸⁹)

Alongside motions to dismiss, creditors can raise objections to derail or delay the bankruptcy, and these objections are often another measure of conflict in a bankruptcy. Kenneth Ayotte and Edward Morrison describe this tactic in a set of large-business bankruptcies, noting that junior creditors raise objections largely to protest maneuvers that transfer value from unsecured to secured credit.²⁹⁰ For holdout creditors in Chapter 9, this is standard fare.²⁹¹

In public-hospital cases, though, the objections tend to be fewer. They are primarily objections to the adequacy of the disclosure statement and to the plan itself. In 34 of 55 cases, at least one creditor objected to the disclosure statement; in 36 of 55, someone objected to the plan.²⁹²

284. App. A (Dockets). Four other cases had objections to the petition, which in some instances can double as a motion to dismiss if the creditor objecting challenges the debtor's eligibility and seeks dismissal as the remedy. Of the four, though, the *Corcoran* and *Shoshone* objections were not publicly accessible. And the *Mendocino* objection did not seek dismissal. See Preliminary Objection at 6, *In re Mendocino Coast Health Care Dist.*, No. 12-12573 (Bankr. N.D. Cal. Dec. 13, 2012), ECF No. 45. Only the *Valley Health System* objection did. See Objection at 11, *In re Valley Health Sys.*, No. 07-18293 (Bankr. C.D. Cal. Jan. 16, 2008), ECF No. 49.

285. Motion to Dismiss, *In re Jack Cnty. Hosp. Dist.*, No. 20-40858 (Bankr. N.D. Tex. May 21, 2020), ECF No. 35.

286. Motion to Dismiss, *In re Hosp. Auth. of Charlton Cnty.*, No. 12-50305 (Bankr. S.D. Ga. May 3, 2012), ECF No. 6.

287. Order Dismissing Case, *In re Avenal Hosp. Dist.*, No. 93-15960 (Bankr. E.D. Cal. Oct. 5, 1999), ECF No. 36.

288. See Status Conference Statement at 1, *In re Indian Valley Healthcare Dist.*, No. 03-32839 (Bankr. E.D. Cal. July 9, 2012), ECF No. 187.

289. App. A (Dockets).

290. Kenneth M. Ayotte & Edward R. Morrison, *Creditor Control and Conflict in Chapter 11*, 1 J. LEGAL ANALYSIS 511, 514, 526-27 (2009) (noting that common objections are to post-petition lending and professional fees). Post-petition lending is uncommon in public-hospital bankruptcies, which may explain the lack of objections on that front. See *supra* ___. And Chapter 9 imposes no restrictions on professional fees, which explains the lack of those objections. See Coordes, *supra* note 23, at 326; 11 U.S.C. § 901 (2018) (not incorporating 11 U.S.C. § 327 (2018) (regulating the employment of professionals)).

291. Coordes, *Restructuring*, *supra* note 23, at 333-35.

292. App. A (Dockets).

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That is overinclusive, though, as anyone can object, and an objection from one creditor does not indicate prevailing sentiment. If, as Ayotte and Morrison do, we instead limit the objections to the unsecured creditors committee—a body that represents the creditors’ interests as a whole—there are only 17 cases (31%) with an objection, compared with the 71% that Ayotte and Morrison find in large Chapter 11s.²⁹³ That difference suggests that unsecured creditors are less inclined to upend a public hospital’s bankruptcy than they are to upend a large corporation’s bankruptcy. And it suggests that overwhelmingly creditors are well-served by, and agreeable to, the Chapter 9 process.

Another possible tactic for creditors is the adversary proceeding. Adversary proceedings take time and resources because they replicate trials on discrete issues in the bankruptcy.²⁹⁴ So a creditor seeking to upend a bankruptcy, or extract value, can file an adversary proceeding (instead of settling, or simply not asserting a right).²⁹⁵

In the public-hospital cases, creditors filed adversary proceedings in 13 of the 55 cases (24%).²⁹⁶ That 24% figure tracks what Baird and Morrison found in Chapter 11 cases where a plan was confirmed (as almost all public hospital cases are), namely, that 30% of such cases had at least one adversary proceeding.²⁹⁷ So adversary proceedings do not appear to be used in Chapter 9 to an extent that suggests creditors are using them as a routine tactic for extracting value from the debtor.

All in all, then, creditors in public hospitals do not appear to be using their available levers to terminate the bankruptcy, frustrate the bankruptcy, or to extract more value from the debtor than they are entitled to. Rather, contrary to the conventional wisdom about fractious government

293. Compare App. A (Dockets), with Ayotte & Morrison, *supra* note 290, at 527 tbl.8. Necessarily there are differences between large businesses and public hospitals, which tend to be medium-sized businesses. But there are no analyses of objections in other bankruptcies that would be more comparable to the public hospitals analyzed here. And more generally, the significantly lower number of objections in hospital cases still suggests that they are a lower-conflict type of bankruptcy.

294. See Michael A. Francus, *Texas Two-Stepping Out of Bankruptcy*, 120 MICH. L. REV. ONLINE 38, 43-44 (2022).

295. Matthew A. Bruckner, *Improving Bankruptcy Sales by Raising the Bar: Imposing a Preliminary Injunction Standard for Objections to § 363 Sales*, 62 CATH. U. L. REV. 1, 14-16 (2012). In a survey of all business cases in the Northern District of Illinois in 1998, Douglas Baird and Edward Morrison found that only 12% of Chapter 11 business cases had an adversary proceeding. Douglas G. Baird & Edward R. Morrison, *Adversary Proceedings in Bankruptcy: A Sideshow*, 79 AM. BANKR. L.J. 951, 956-58 & tbl.2 (2005). This sample, though, includes many small businesses and so it is not comparable to public hospitals. See *id.* at 963 (noting that the adversary proceeding cases tend not to be small business cases). Rather, a more apt comparison would be cases of similar complexity and size, such as business cases that confirm a plan.

296. App. A (Dockets). Debtors can, and do, file adversary proceedings. But these are, by definition, not aimed at delaying the debtor’s case. They instead aim to recover preference payments or contest the validity of claims. See FED. R. BANKR. P. 7001 (outlining the scope of adversary proceedings).

297. Baird & Morrison, *supra* note 295, at 961.

bankruptcies, public-hospital bankruptcies seem to be relatively peaceful affairs.

Communities and Politics in Public-Hospital Bankruptcies. Descriptively, communities focus their efforts on saving the hospital, not on shifting losses to others. They can, of course, individually benefit from employment, keeping steady Medicare and Medicaid revenue, and having access to health care. But all participants in the bankruptcy take steps beyond that self-interest to save the hospital.

Start with the community's expressed attitude. Across the board, the aims of the community are to maintain their hospital. Many districts note as much in their filings, writing, for example, that "Goal 1" is to keep the hospital.²⁹⁸ In community meetings, letters to the editor, and other public fora, the board of the hospital and citizenry describe their goal as preserving the hospital. At a public meeting about Palm Drive Hospital, for instance, one former board president stated, "[A]ll we want them to do is keep the lights on and the water running."²⁹⁹ Or, as one resident of Pushmataha County put it, "For the county's sake [Pushmataha Hospital] needs to stay open."³⁰⁰ Such sentiments abound.

Concrete evidence also reflects that sentiment. In the Chambers County Hospital bankruptcy, the hospital conducted a survey showing that 76% of residents wanted to keep the hospital.³⁰¹ Residents back up those poll numbers, often voting to raise their own taxes to help the hospital.³⁰² Sometimes they provide support through donations.³⁰³

Government in Public-Hospital Bankruptcies. Other government entities do not play a major role in public-hospital bankruptcies. But when they show up, they likewise focus on helping the hospital persist. For ex-

298. Disclosure Statement at 2, *In re Natchez Reg'l Med. Ctr.*, No. 09-00477 (Bankr. S.D. Miss. Feb. 12, 2009), ECF No. 18; *see also Taking a Closer Look at Debt Ridden Pushmataha Hospital*, KTEN (Sept. 29, 2016) <https://www.kten.com/story/33283961/taking-a-closer-look-at-debt-ridden-pushmataha-hospital> [<https://perma.cc/NAN5-Y3GE>] (quoting the Pushmataha Hospital board chairman, who stated that "[o]ur main goal is to keep the hospital open").

299. Martin Espinoza, *Palm Drive Hospital Votes to Close Core Services, Files for Bankruptcy*, PRESS DEMOCRAT (Apr. 7, 2014), <https://www.pressdemocrat.com/article/news/palm-drive-hospital-votes-to-close-core-services-files-for-bankruptcy> [<https://perma.cc/KT6R-ELB6>].

300. *Taking a Closer Look at Debt Ridden Pushmataha Hospital*, *supra* note 298.

301. Disclosure Statement at 17, *In re Chambers Cnty. Hosp. Dist. No. 1*, No. 00-80240 (Bankr. S.D. Tex. July 1, 2003), ECF No. 109.

302. *E.g.*, Disclosure Statement at 25, *In re Iron Cnty. Hosp. Dist.*, No. 18-10111 (Bankr. E.D. Mo. Dec. 9, 2019), ECF No. 249; Disclosure Statement at 7, *In re W. Contra Costa Cnty. Healthcare Dist.*, No. 16-42917 (Bankr. N.D. Cal. Aug. 3, 2017), ECF No. 146; Disclosure Statement at 15, *In re Pauls Valley Hosp. Auth.*, No. 13-10791 (Bankr. W.D. Okla. Dec. 11, 2015), ECF No. 313; *see also* Disclosure Statement at 17-18, *In re Chambers Cnty. Hosp. Dist. No. 1*, No. 00-80240 (Bankr. S.D. Tex. July 1, 2003), ECF No. 109 (noting voter acquiescence to a hospital's tax increase).

303. *E.g.*, Disclosure Statement at 18, *In re S. Inyo Healthcare Dist.*, No. 16-10015 (Bankr. E.D. Cal. Mar. 12, 2020), ECF No. 908; *Taking a Closer Look at Debt Ridden Pushmataha Hospital*, *supra* note 298.

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ample, some pitch in funds to help stabilize the hospital. The City of Watonga issued bonds to fund Watonga Hospital.³⁰⁴ Iron County passed a sales tax for its hospital.³⁰⁵ Adair County loaned Adair County Hospital \$1.5 million before its bankruptcy to keep it afloat and did not receive repayment in the bankruptcy.³⁰⁶

Medicare is the largest repeat player in these cases and could shut down any of the hospitals by withholding future funds based on prebankruptcy overpayments. And in cases where Medicare funds were obtained by fudging the hospitals' reimbursement information, the obligations to Medicare are likely not dischargeable.³⁰⁷ Yet Medicare regularly settles overpayment issues or works with hospitals to keep them afloat. The best example of Medicare's efforts is seen in Watonga Hospital's bankruptcy. There, past management overcharged Medicare, leading to Medicare claiming overpayments and a lawsuit by the hospital against management.³⁰⁸ Watonga Hospital settled the case for \$250,000, and Medicare, in turn, settled its overpayment claims against Watonga Hospital for \$250,000.³⁰⁹

Other regulators seldom appear. For example, no case involved an antitrust regulator. That owes, in part, to many hospitals already being the sole provider in their area.³¹⁰ Also, antitrust regulators can achieve their regulatory aims after the bankruptcy as well, which may explain their hesitancy (and the hesitancy of health regulators) to deal with the hassles of bankruptcy. Regardless, these other regulators are not appearing in the bankruptcy and attempting to upend the proceedings.³¹¹

304. Plan at 13-14, *In re Watonga Hosp. Tr. Auth.*, No. 04-10415 (Bankr. W.D. Okla. Mar. 21, 2006), ECF No. 67.

305. Jenkins, *supra* note 154.

306. Disclosure Statement at 5, 10, *In re Adair Cnty. Hosp. Dist.*, No. 13-10940 (Bankr. W.D. Ky. Dec. 18, 2015), ECF No. 316.

307. See 11 U.S.C. § 523(a)(2)(A) (2018). Overpayments can occur as forms of soft fraud, where the hospital codes treatment to obtain a better reimbursement rate instead of billing the treatment for what it was. See David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. LEGAL STUD. 531, 540-48 (2001) (describing how physicians, regulators, fraud-control personnel, and the public view different forms of Medicare fraud).

308. See *supra* Section I.A.3 (discussing gross mismanagement at Watonga).

309. See *supra* Section I.A.3. Other agencies are similar. In Kingsburg's bankruptcy, for example, the IRS voluntarily reduced its claim against the hospital by waiving amounts that were penalties or accrued interest. Plan at 5, *In re Kingsburg Hosp. Dist.*, No. 97-15254 (Bankr. E.D. Cal. Nov. 18, 1999), ECF No. 110. This is in keeping with recent work on how governments use bankruptcy to achieve policy aims. See generally Jared A. Ellias & George Triantis, *Government Activism in Bankruptcy*, 37 EMORY BANKR. DEVS. J. 509 (2021).

310. Other reasons might also explain the lack of antitrust in particular, like the failing firm defense or the general exemption of governments from antitrust law. Many thanks to Daniel Francis and Maria Maciá for pointing these out to me.

311. For an argument that regulators should take a more aggressive stance toward antitrust in rural healthcare, see generally Theodosia Stavroulaki, *The Healing Power of Antitrust*, 119 NW. U. L. REV. (forthcoming 2025).

Politicians and Politics in Public-Hospital Bankruptcies. Apart from creditors, Chapter 9’s limitations on interfering with political and governance powers do little to prevent hospital reorganizations. There are three main reasons for this.

First, few of the hospitals’ woes stem from politics. The data reveal that Medicare cuts and Medicaid cuts often drive these bankruptcies.³¹² Local politicians have no control over that. Likewise, population decline (the secondary cause of these bankruptcies³¹³) tends to follow a secular trend: people migrate from rural to urban areas. So even if politics does not solve problems for public hospitals, it at least does not cause them, either.

Second, the elected board has only one incentive: save the hospital.³¹⁴ That is what the community—including creditors—wants as well. Unlike a city’s bankruptcy, where politics permeates the hard tradeoffs (imagine a choice between cutting police, bus routes, or pensions), here the parties’ politics align in the same direction. That means politics may *help* public hospitals in bankruptcy.³¹⁵

Third, if politics is a problem in a particular public-hospital bankruptcy, privatization can fix the problem. A sale changes hospital governance by shifting responsibility from elected officials to professional hospital managers.³¹⁶ The result is the governance reform that critics long for in political-subdivision bankruptcies.

Incoherence. Public-hospital bankruptcies also do not suffer from the mismatch between Chapter 11’s property approach to bankruptcy and Chapter 9’s disregard for many traditional property concepts in bankruptcy. To the contrary, these bankruptcies follow priority closely. Notably, secured creditors received full payment in every plan, so there is never a violation of absolute priority.³¹⁷

Relief Too Late. Nor does the insolvency requirement seem to pose a challenge for public hospitals. If it did, more hospitals would follow the

312. See *supra* Section I.A.1.

313. See *supra* Section I.A.2.

314. See Henry Hansmann & Connor Clarke, *Between Public and Private Enterprise: The Role and Structure of Special-Purpose Governments* 21 (Aug. 1, 2023) (unpublished manuscript) (on file with author) (noting that special-purpose governments “usually provide only a single service”)

315. Cf. Kane, et al., *supra* note 18 at 1680 (finding that hospitals governed directly by elected officials had higher profit margins than other safety-net hospitals).

316. See, e.g., Ayla Ellison, *For-Profit Hospital Chain Closes \$78M Deal for Washington Health Systems*, BECKER’S HOSP. REV. (Aug. 6, 2018), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/for-profit-hospital-chain-closes-78m-deal-for-washington-health-system.html> [<https://perma.cc/8NYF-TEYR>]; Rege, *supra* note 254 (noting that Saint Francis Health System’s purchase of Craig County Hospital offered “stability”); *Voters Green-Light Affiliation with Adventist Health*, FORT BRAGG ADVOCATE-NEWS (Mar. 4, 2020), <https://www.advocate-news.com/2020/03/04/voters-green-light-affiliation-with-adventist-health> [<https://perma.cc/EU44-NN69>].

317. App. D (Plans).

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tack of Indian Valley, dismissing their own bankruptcies because they could not afford it,³¹⁸ or failing to approve plans because they are unfeasible. Yet, overwhelmingly, the public hospitals do confirm a plan—in 50 of 55 cases.³¹⁹ And the low rate of relapses, along with the qualitative analysis of the bankruptcies,³²⁰ suggest that the delay caused by the higher burden does not translate into many bankruptcy failures.

C. Rethinking Government Bankruptcy

In broader perspective, these public hospital bankruptcies suggest that there are really two types of government bankruptcy: political-subdivision bankruptcy and government-business bankruptcy. Chapter 9 works well for the businesses. Scholars have written about the challenges of Chapter 9 for political subdivisions and have many valid criticisms there.³²¹ But criticisms and reform efforts should not throw the baby out with the bathwater: in efforts to improve bankruptcy for cities, we should not ruin it for public hospitals. In fact, Chapter 9's efficacy for public hospitals should encourage more states to allow their government businesses access to Chapter 9.

Politics. The bankruptcy of a town, city, or county is fundamentally about politics. Communities hotly debate pension cuts, service reductions, tax increases, and countless other value-laden questions like whether to sell the museum's art collection.³²² Invariably, the state must make some decisions—to bail out the city, to take control of budgets, to displace local governance altogether,³²³ to dissolve the municipality. In these bankruptcies, the tools of Chapter 9 may offer little, because the bankruptcy—even when it is about financial distress—is still about the political choices that led to that distress and the political choices that are needed to relieve it.

Detroit, Stockton, San Bernardino, Bridgeport, Orange County, and Jefferson County all attest to this, as many scholars have shown.³²⁴ These government bankruptcies are, at their core, political, and hence highlight the challenges of bad governance for a municipal bankruptcy regime.

318. Civil Minute Order, *In re* Indian Valley Healthcare Dist., No. 03-32839 (Bankr. E.D. Cal. Sept. 24, 2012), ECF No. 197 (dismissing the case).

319. App. A (Dockets). One case, Surprise Valley Hospital, remains pending. The five that did not confirm plans were the ones that were dismissed: Indian Valley Hospital, Avenal Hospital, Charlton County Hospital, Whitney Hospital, and Jack County Hospital (in its first bankruptcy).

320. *See supra* Section I.D.1.

321. *See supra* Section II.A.

322. *See, e.g.,* Maureen B. Collins, *Pensions or Paintings? The Detroit Institute of Arts from Bankruptcy to Grand Bargain*, 24 U. MIAMI BUS. L. REV. 1, 2-3 (2015).

323. Clayton P. Gillette, *Dictatorships for Democracy: Takeovers of Financially Failed Cities*, 114 COLUM. L. REV. 1373, 1376-77 (2014).

324. *See sources cited supra* notes 19-27.

Business. But the vast majority of Chapter 9 bankruptcies are not Detroit. Rather, five out of six are government businesses—hospitals, utility districts, and so on.³²⁵ Public hospitals *alone* account for almost one-fourth of Chapter 9 cases.³²⁶

And these bankruptcies, even when they involve entities with elected leaders, do not face the governance problems that critics see plaguing Chapter 9. Political fights are less likely to arise when the only thing people want is to save their community hospital, sewers, water system, or the like. In these cases, the questions are not those of community values (which are widely agreed upon) but of technical competence: How can we make the hospital sustainable? What services can the hospital provide profitably? Who can best run the hospital? Bankruptcy law, as the public hospitals show, is well-equipped to shepherd a process that centers on answering those questions.

Keeping and Expanding Chapter 9. In the government-business world, where consensus already reigns, Chapter 9 has much to offer. So Chapter 9 could be a more valuable tool for states that authorize it. Instead of having these failed-but-critical services, like hospitals and utilities, close, states could allow them to file for bankruptcy and resolve their financial issues in a way that maintains the community's access to valuable services. At a minimum, reformers of Chapter 9 should exercise caution and ensure that any changes aimed to improve the chapter for political subdivisions does not undercut its value for government businesses.³²⁷

III. Lessons for Policy

The analysis above suggests that bankruptcy works for public hospitals and that states should use it. Because of the federalism constraints, though, public hospitals may only file if “specifically authorized” by the state.³²⁸ About half the states so authorize.³²⁹ Of those that authorize, a dozen impose procedural or substantive hurdles before a public hospital

325. James Spiotto & Jeff Garceau, *Chapter 9 Municipal Bankruptcy Statistics: Use by Number, Type, and Year*, MUNINET GUIDE (June 14, 2018), <https://muninet.harris.uchicago.edu/2018/06/14/municipal-bankruptcy-statistics> [<https://perma.cc/4H77-QPLS>]. For an overview of how government business came to predominate, see generally Michael A. Francus, *Failing Better* (Feb. 21, 2024) (unpublished manuscript), <https://ssrn.com/abstract=4734561> [<https://perma.cc/L6L2-VKGE>] (reviewing David Schleicher, *IN A BAD STATE: RESPONDING TO STATE AND LOCAL BUDGET CRISES* (2023)).

326. See *supra* note 47.

327. See, e.g., Clayton P. Gillette & David A. Skeel, Jr., *Governance Reform and the Judicial Role in Municipal Bankruptcy*, 125 *YALE L.J.* 1150, 1153-54 (2016) (arguing for empowering bankruptcy judges to undertake governance reforms in Chapter 9 cases).

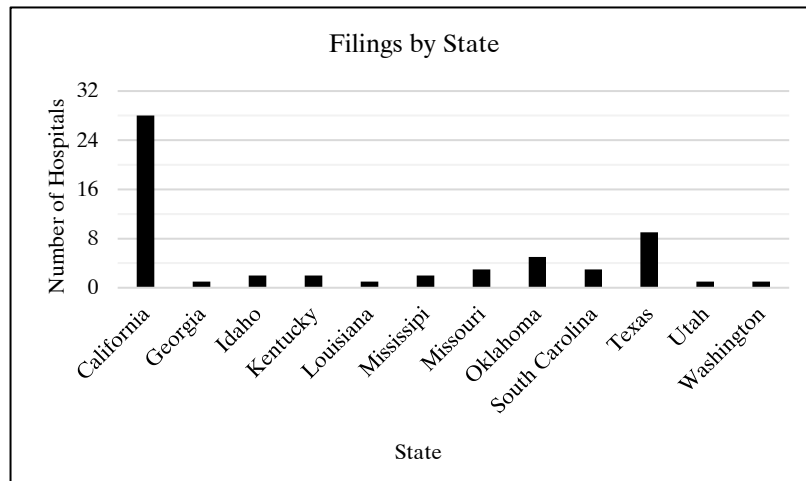
328. 11 U.S.C. § 109(c)(2) (2018).

329. See K&L GATES, *STATE STATUTES AUTHORIZING MUNICIPAL BANKRUPTCY* 1-3 (June 26, 2015) [<https://perma.cc/SL38-B5V8>] (specifying the authorization status for each state).

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may file—typically requiring a particular state official³³⁰ or relevant state agency³³¹ to approve the filing. The result is a skew limiting which public hospitals can use bankruptcy in practice.³³²

Figure 10



For states that do not authorize bankruptcy for public hospitals, the question is what alternatives fare better. As this Part shows, there are none. Traditional means of addressing business failure do not work for public hospitals. Bankruptcy, therefore, uniquely adds to the toolkit for public hospitals, can save some that would otherwise fail, and should be authorized by states that currently do not.

A. Why the Alternatives Don't Work

Bankruptcy is rare. Even among businesses that close, fewer than twenty percent file for bankruptcy.³³³ Instead, they rely on a menu of

330. For example, Connecticut requires the governor's approval before a district can file. CONN. GEN. STAT. § 7-566 (2023). Michigan requires approval from the governor as well. MICH. COMP. LAWS § 141.1558(1) (2024). Kentucky requires approval from two state officials. KY. REV. STAT. ANN. § 66.400 (West 2021).

331. *E.g.*, N.J. STAT. ANN. § 52:27-40 (West 2023) (requiring approval from the municipal finance commission); N.C. GEN. STAT. § 23-48 (2023) (requiring approval from the Local Government Commission); OHIO REV. CODE ANN. § 133.36 (West 2023) (requiring approval from the tax commissioner); R.I. GEN. LAWS § 45-9-7(b)(3) (2024) (requiring approval from a receiver appointed under the state's Fiscal Stability Act). The difference between requiring governor approval and agency approval turns on a state's judgement as to whether municipal crises are better handled by politics (hence, the governor) or technical expertise (hence, an agency).

332. App. A (Dockets). Note that Georgia forbids its public hospitals to file. The case there was promptly dismissed. *See* notes 223-227 and accompanying text.

state-law options for handling the business' distress, including assignment for the benefit of the creditors, foreclosure, receivership, composition, workouts, sales, and bailouts. But all of these are problematic for a public hospital.

Assignment. One popular option for failed businesses is an assignment for the benefit of the creditors.³³⁴ An assignment is much like a trust—the business assigns its assets to an assignee, who is charged with liquidating the assets and distributing value to the creditors according to state-law priorities.³³⁵ The business cannot receive a discharge under state law, but it dissolves, functionally eliminating the business' liabilities and leaving creditors to collect *only* against the assignee.³³⁶

For public hospitals, this bankruptcy analog does not work. In an ordinary assignment, creditors cannot continue pursuing the business because it dissolves. But a public hospital (like an individual debtor) does not dissolve, so an assignment would leave creditors returning to the hospital district indefinitely to collect.³³⁷ That result is particularly difficult when the hospital reorganizes (instead of privatizing), as new creditors must worry about old debt, and the hospital can slouch into debt overhang, with new creditors refusing to lend to the reorganized hospital.³³⁸

“Friendly” Foreclosure. Occasionally, a failed business will wind up by allowing a foreclosure. To do so, the business surrenders to the secured creditor her collateral.³³⁹ Other creditors are then left with whatever remains (if anything) and the business, as with an assignment, dissolves.

This option, however, falters for public hospitals twice over. First, anti-attachment laws typically prevent such foreclosures, so even secured creditors cannot take assets to satisfy old debts.³⁴⁰ Second, public hospi-

333. Edward R. Morrison, *Bargaining Around Bankruptcy: Small Business Workouts and State Law*, 38 J. LEGAL STUD. 255, 256 (2009).

334. *Id.* at 257 (noting that assignment for the benefit of creditors is almost as popular as bankruptcy for failed businesses).

335. Andrew B. Dawson, *Better than Bankruptcy?*, 69 RUTGERS U. L. REV. 137, 145 (2016).

336. *Id.* at 147-48. This is also why individuals do not use assignments for the benefit of the creditors (ABCs) for their debts.

337. David A. Skeel, Jr., *States of Bankruptcy*, 79 U. CHI. L. REV. 677, 683 (2012) (noting that Chapter 9 is a closer analogue to individual bankruptcy than corporate bankruptcy for this reason). It is also unlikely that dissolution *would* be desirable if possible. Dissolving the hospital would shift the debt up to a higher level of government (like the county or city) rather than make the debt disappear. *See* Joffe, *supra* note 222 (explaining the dynamics of this option for West Contra Costa Healthcare District).

338. *See* Buccola, *supra* note 25, at 845.

339. *See* Philip J. Hendell, *The Friendly Foreclosure: Using Rev. Article 9-620 as a Vehicle to Preserve the Going Concern Value of a Closely Held Business*, 16 COM. L. BULL. 16, 16-18 (2001) (describing the friendly-foreclosure process).

340. *See, e.g.*, WASH. REV. CODE § 6.17.080 (2023); KY. REV. STAT. ANN. § 66.400(5)(a) (West 2021).

tals do not dissolve at the end of a friendly foreclosure, leading to the same problems as an assignment even if such anti-attachment laws were abrogated.

Receivership. A receivership, much like an assignment, puts the business's assets in the hands of a third party to address debt issues and repay creditors. Such receiverships were quite popular among businesses, notably nineteenth-century railroads, before federal bankruptcy law was an option.³⁴¹

A receivership, though, presents the same problem for public hospitals as an assignment does.³⁴² Railroad receiverships relied on selling assets and dissolving the prior railroad corporation.³⁴³ But a public hospital does not dissolve, so the creditors will keep returning to the hospital district for payment and a receivership thus cannot resolve a public hospital's debt problems.

Composition. Under a state-law composition, creditors can vote to write down their debt. If enough agree, other creditors are bound by the write down and will receive cents on the dollar, allowing the debtor to achieve a sustainable debt load and escape its financial distress. Such state-law compositions once aided governments in alleviating debt problems. And the Supreme Court upheld compositions in *Faitoute Iron & Steel Co. v. City of Asbury Park*, where a New Jersey law permitted creditors of Asbury Park to write down their debt if holders of 85% of the debt agreed.³⁴⁴

But Congress has since preempted those compositions. Under the current Code, "a State law prescribing a method of composition of indebtedness of such municipality may not bind any creditor that does not consent."³⁴⁵ So states no longer have the option of creating a bankruptcy parallel for their public hospitals.³⁴⁶

Out-of-Court Workouts. Creditors, even absent a composition, can contract amongst themselves to write down debt. That can achieve the same result as a composition if all parties consent.

Therein lies the challenge for public hospitals. For one, public hospitals have many, diffuse creditors, making unanimous consent unlikely and

341. See Stephen J. Lubben, *Railroad Receiverships and Modern Bankruptcy Theory*, 89 CORNELL L. REV. 1420, 1430-31 (2004).

342. See Laura N. Coordes, *A Proactive Approach to Hospital Financial Health*, 95 AM. BANKR. L.J. 33, 45-46 (2021).

343. See Lubben, *supra* note 341, at 1444-45 (noting that dissolution "effectively discharged" railroads' debts by leaving no assets for creditors).

344. 316 U.S. 502, 506-09 (1942).

345. 11 U.S.C. § 903(1) (2018).

346. For arguments that such parallels would be a benefit, see McConnell & Picker, *supra* note 21, at 479-81; and George Triantis, *Bankruptcy for the States and by the States*, in WHEN STATES GO BROKE, *supra* note 279, at 237, 240-44.

bargaining failures inevitable.³⁴⁷ On top of that, workouts happen in the shadow of the law: creditors agree to the workout because they know what the law's alternative will be and prefer a workout to the alternative.³⁴⁸ But for public hospitals, the alternative (absent bankruptcy) is to keep paying, so creditors have every reason to hold out and prevent a workout agreement from being reached.

Bailout. One rare option for private businesses is a bailout. Typically, in a free market, bailouts are shunned, reserved for the rare cases of systemically important institutions like GM, Chrysler, AIG, or banks.³⁴⁹ But for government entities, subsidies and bailouts (especially by a state or its local governments) are accepted facts of life. As David Schleicher notes, there is a long history of such bailout relief at all levels of government, dating back to the federal government assuming state war-related debts after the Revolution.³⁵⁰

This generosity, though, has not typically been extended to public hospitals. While many states subsidize their public hospitals, those subsidies rarely suffice, especially when states face budget challenges.³⁵¹ And here the politics are against public hospitals. The indigent patients they serve have little political voice and statewide politicians do not view a particular hospital as systemically important along the lines of, say, Chrysler. The result is that subsidies and bailouts have not proven a viable means of ensuring financial stability for distressed public hospitals.

Sale. That leaves the option of selling a failed business. If all the assets are sold together, successor-liability doctrine will likely require the buyer to take those assets subject to the predecessor's liabilities.³⁵² And even if the assets are sold piecemeal, security interests will follow the assets,³⁵³ meaning that much of the business's liability cannot be shed through a sale.

347. See Mark J. Roe, *Bankruptcy and Debt: A New Model for Corporate Reorganization*, 83 COLUM. L. REV. 527, 539 (1983).

348. See Alan Schwartz, *Bankruptcy Workouts and Debt Contracts*, 36 J.L. & ECON. 595, 597-98 (1993) (attributing some workout failures to this problem).

349. Adam J. Levitin, *In Defense of Bailouts*, 99 GEO. L.J. 435, 437-39 (2011)

350. See generally David Schleicher, Hands On! Part I: The Trilemma Facing the Federal Government During State and Local Budget Crises 15-53 (July 12, 2020) (unpublished manuscript), <https://ssrn.com/abstract=3649278> [<https://perma.cc/V4FP-ATLK>] (recounting the history of federal intervention).

351. Needleman & Ko, *supra* note 6, at 200 (discussing cuts in the wake of the 2008 recession); Kane et al., *supra* note 18, at 1686 ("Local taxpayer subsidies and generous Medicaid supplemental benefits are highly vulnerable to economic downturns."); Anderson et al., *supra* note 30, at 1166 (recounting Texas's 2003 cuts to Medicaid). This has also been confirmed by practitioners.

352. Michael H. Reed, *Successor Liability and Bankruptcy Sales*, 51 BUS. LAW. 653, 653 (1996); Marie T. Reilly, *Making Sense of Successor Liability*, 31 HOFSTRA L. REV. 745, 746 n.3 (2003) (collecting sources demonstrating when courts impose successor liability).

353. U.C.C. § 9-315(a) (AM. L. INST. & UNIF. L. COMM'N 2010).

Death, Bankruptcy and the Public Hospital

The continuation of liability is a problem for private and public debtors alike if the liabilities exceed the assets. For example, if a private corporation owns a mining operation with assets of \$10 million and liabilities of \$5 million, it will be able to find a buyer. But if the liabilities jump to \$15 million and cannot be shed in a sale (thanks to successor liability), the corporation is now worth negative \$5 million, which will preclude a buyer from acquiring all the assets of the corporation. The same logic holds for public hospitals. That logic, in turn, suggests that sales cannot work for the hospital if liabilities exceed assets, which is typically the case for a bankrupt public hospital.

B. Why Bankruptcy Works

Bankruptcy helps public hospitals surmount the challenges they would face using ordinary state-law tools to address their financial distress. For reorganization, bankruptcy's discharge is key. For sales, bankruptcy's free-and-clear sale does the crucial work. In either instance, though, bankruptcy offers public hospitals a route to survival and thus can save some hospitals that would otherwise close.

Reorganization. For a reorganizing public hospital, the main problem is past debt. Because the hospital cannot dissolve or otherwise shed past debt, it runs the risk of debt overhang going forward. That is, new creditors (employees, banks, and vendors) will not contract with the hospital because they will fear that hospital revenues will be used to repay old debt instead of new creditors. By way of example, if nurses know that new hospital revenues will be used to pay bank debt instead of nurses' salaries, they will not show up for work and the hospital will cease to function.

By offering a discharge, bankruptcy solves this problem. The discharge ensures that prebankruptcy creditors can recover from the bankruptcy but cannot reach assets going forward.³⁵⁴ That eliminates debt overhang, enabling a reorganized hospital to access the vendors, employees, banks, and others it needs to succeed.

Sales. For a hospital that uses Chapter 9 to privatize, the main issue is finding a buyer. Buyers, though, may be wary of successor liability.³⁵⁵

Bankruptcy can help here too. A free-and-clear sale enables buyers to take the public hospitals' assets without also taking the prebankruptcy liabilities.³⁵⁶ To return to the mining-corporation example, an acquirer

354. Marcus Cole, *Limiting Liability Through Bankruptcy*, 70 U. CIN. L. REV. 1245, 1252 (2002).

355. See, e.g., *KSP Investigating Local Hospitals*, *supra* note 84 (explaining that Adair County Hospital could not find a buyer because of its \$18 million of debt).

356. 11 U.S.C. § 363(f) (2018). Mark Roe notes this issue in the mass-tort context, concluding that bankruptcy could help resolve mass tort's successor-liability problem. Mark J.

could now buy its assets (worth \$10 million) without its liabilities, making the sale attractive up to a price of \$10 million (which, in turn, is used to pay prebankruptcy creditors). That free-and-clear sale, then, acts as a subsidy to the buyer and enables public hospitals to privatize instead of close when a buyer wants to buy the hospital but will not do so because the successor liability is too great.

So, regardless of how a public hospital wishes to use bankruptcy, bankruptcy law offers an advantage unavailable under state law. Reorganizations benefit from bankruptcy's discharge and sales benefit from bankruptcy's free-and-clear sale provisions. The result in either case helps a distressed public hospital survive and does so when state law cannot. That should encourage states to expand eligibility for Chapter 9 at least to their public hospitals, and likely to all their government businesses.

Conclusion

In an era of widespread fiscal distress, state and local governments need to plan for public finance gone wrong. That is especially true in the realm of public health, where the danger threatens a basic service for those least able to access it. To date, though, state and local governments have largely ignored bankruptcy as a tool to help when public hospitals and other government businesses encounter fiscal crises. While much scholarship supports that position through critiques of Chapter 9's headline cases, the public-hospital cases analyzed in this Article show that Chapter 9 can work, even when alternatives do not. Bankruptcy helps preserve hospitals in communities that need them, maintaining care that would otherwise disappear. Because bankruptcy may often be the only means of saving public hospitals, states should authorize public hospitals to file for bankruptcy.

Roe, *Mergers, Acquisitions, and Tort: A Comment on the Problem of Successor Corporation Liability*, 70 VA. L. REV. 1559, 1578-79, 1598-99 (1984).