2005

Not So Perfect: The Disconnect between Medicare and the Uniform Commercial Code regarding Health-Care-Insurance Receivables

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I. INTRODUCTION

Imagine that you or your loved one has just been involved in a serious auto accident. You feel fortunate because you know that one of the best trauma centers in the city is close by. But the ambulance ride is taking longer than expected. With the chances of survival lessening every minute, you hear the ambulance driver tell the paramedics that they have been asked to divert to another emergency room across town. The trauma center that was so critical to your future has been temporarily forced to close its doors to new patients because it is short-staffed and under-funded.

While this may seem like a scene out of the hit television drama ER, it is a reality in many hospitals across America where medical resources are stretched to the breaking point. Health care providers in desperate need of financing find it increasingly difficult to obtain the funds necessary to operate their facilities. Investors’ lack of confidence in health care financing is a primary reason behind this shortage of funding. One solution for restoring lender confidence would be to reconcile the Medicare and Medicaid (Medicare) anti-assignment

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1. ER (NBC television broadcast, Sept. 19, 1994).
2. See CTRS. FOR MEDICARE AND MEDICAID SERVS., HEALTH CARE INDUSTRY MARKET UPDATE, ACUTE CARE HOSPITALS 21 (July 14, 2003), available at www.cms.hhs.gov/reports/hcimu/hcimu_07142003.pdf [hereinafter ACUTE CARE HOSPITALS] (noting that there has been an increase in credit rating downgrades in the health care industry for the first part of 2003).
3. Id. Bank consolidations and skepticism by lenders regarding health care borrowers caused a decline in syndicated loans to the health care industry, from $8.9 billion in 2001 to $2.7 billion in 2002. Id.
4. See Hearing on Medpac Report on Medicare Payment Policies Before the Health Subcomm. of the House Comm. on Ways and Means, 108th Cong. (2003), available at http://waysandmeans.house.gov/hearings (statement of Mary K. Ousley, Chairman, American Health Care Association) (discussing the bleak financial status of the health care industry as a whole, pointing out that critical statistics and coverage ratios used by lenders in evaluating potential borrowers were below the point of acceptability for a majority of the sector, and stating that one third of the industry is insolvent, causing lenders to have an overall negative impression of health care borrowers).
provisions with the Uniform Commercial Code (the UCC) provisions, which would allow health care providers to leverage their Medicare health-care-insurance receivables and the related deposit accounts in a secured lending transaction.

Part II of this Note compares the UCC's secured transactions laws to the Medicare statutes, and points out how the two bodies of law are in conflict with one another on the issue of health-care-insurance receivables. Part III discusses ways in which a secured lender may seek to perfect a security interest in Medicare health-care-insurance receivables and whether or not a secured lender should include the value of those receivables in the debtor's borrowing base. Part IV discusses the negative impact that the Medicare anti-assignment provisions have on the ability of health care providers to obtain financing through secured lending. Part V proposes either elimination or restructuring of the anti-assignment provisions of the Medicare statutes enabling lenders to take assignments of Medicare health-care-insurance receivables as part of the collateral in an asset-based secured financing.

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6. U.C.C. § 9-310 (governing perfection of a security interest by filing a financing statement); § 9-312 (governing perfection of security interests in deposit accounts); § 9-314 (defining perfection by control); § 9-315 (governing security interest attachment in identifiable cash proceeds); § 9-408 (detailing restrictions on assignments of health-care-insurance receivables); § 9-607 (establishing collection and enforcement remedies available to secured parties) (2001).

7. See infra notes 179-200 and accompanying text.


9. See infra notes 13-52 and accompanying text.

10. See infra notes 53-157 and accompanying text.

11. See infra notes 158-178 and accompanying text.

12. See infra notes 179-200 and accompanying text.
II. HEALTH-CARE-INSURANCE RECEIVABLES: RECEIVING DIFFERENT TREATMENT UNDER THE UCC AND MEDICARE STATUTES

A. Health-Care-Insurance Receivables under the UCC

A new breed of collateral introduced in the 2001 revisions to Article 9,13 "health-care-insurance receivables"14 is considered a subset of "accounts."15 In a traditional secured loan transaction where accounts receivable are part of the collateral used to secure a loan, the secured lender files a financing statement16 to perfect its security interest in the accounts.17 As with other accounts, security interests in health-care-insurance receivables may be perfected through the filing of a financing statement.18 In addition to perfecting a security interest in the health-care-insurance receivables, the secured lender may also seek to perfect its security interest in the deposit account19 where the cash proceeds20 from the health-care-insurance receivables are deposited when the receivables are paid.21

To perfect a security interest in a deposit account as original collateral,22 the secured lender must have control of the deposit account.23 Control is achieved by a secured lender in one of three

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13. U.C.C. Art. 9 (2001). Article 9 of the Uniform Commercial Code underwent a major overhaul in July of 2001. Id. Among the changes proposed by the National Conference of Commissioners on Uniform State Laws were the addition of collateral types such as health-care-insurance receivables, changes in the requirements of a financing statement, changes in the mechanism for perfection of a security interest in deposit accounts, and changes in the location of filing. Id. The changes to Article 9 have been adopted by all states with slight variations.


17. U.C.C. § 9-310 (2001) (establishing when a financing statement is required to perfect a security interest).

18. U.C.C. § 9-309 (2001). But see U.C.C. § 9-309 cmt. 5 (2001) (stating that when an individual assigns a payment under a health-care-insurance receivable to a provider, the provider’s security interest in that receivable is perfected upon attachment).


ways: 24 (1) the secured lender may be the depositary bank at which the debtor maintains the deposit account, 25 (2) the secured lender may become the depositary bank’s customer with respect to the deposit account, 26 or (3) the secured lender may enter into a deposit account control agreement. 27

The secured lender may seek to perfect a security interest in both health-care-insurance receivables and the related deposit account into which the debtor deposits the payments made on the receivables, that is, the proceeds of the receivables. 28 Unlike perfection of a deposit account as original collateral, 29 the security interest of the lender attaches to the cash proceeds of the health-care-insurance receivables when the debtor receives the payment. 30 A lender does not need control of the debtor’s deposit account in order to have a perfected security interest in the cash proceeds of the health-care-insurance receivables. 31 However, in order for the secured lender’s security interest to remain perfected, cash proceeds must remain identifiable and must not be commingled with other funds. 32 In order to ensure that the proceeds remain identifiable, a secured lender should require a debtor to deposit the proceeds from Medicare health-care-insurance receivables into an account separate from the proceeds of non-Medicare health-care-insurance receivables. 33

25. U.C.C. § 9-104(a)(1) (2001); see also U.C.C. § 9-340 (2001) (distinguishing between a security interest in a deposit account and a depositary bank’s right of recoupment or set-off). When a secured lender has a perfected security interest through control of a deposit account, pursuant to U.C.C. § 9-104(a)(3), the depositary bank’s right of set-off is ineffective. U.C.C. § 9-340. Also, the depositary bank, acting as a secured lender, may have both a security interest and a right of set-off with respect to the same deposit account. U.C.C. § 9-340.
26. U.C.C. § 9-104(a)(3); see also U.C.C. § 4-401(a), § 4-403(a) (1990) (concerning bank duties generally).
28. See supra note 20 and accompanying text.
29. See supra notes 22-27 and accompanying text.
30. See § 9-315, cmts. 6-7 (2001).
31. Id.
32. See generally U.C.C. § 9-315 (2001). In a financing arrangement where both Medicare receivables and non-Medicare receivables are used as collateral for the loan, it is important that the deposit accounts are segregated, because the deposit account for the non-Medicare receivables can be perfected by control. See supra notes 22-27 and accompanying text. The Medicare receivables deposit account would remain subject to the Medicare anti-assignment provisions. See infra notes 73-77 and accompanying text.
33. See supra note 32.
Despite the best intentions of the drafters of revised Article 9 "to make it easier to create and perfect Article 9 security interests over a greater range of assets," current federal laws regarding Medicare payments do little to further this goal with respect to health-care-insurance receivables. In light of the anti-assignment provisions in Medicare, perfection of security interests in Medicare health-care-insurance receivables offers a meaningless protection, devoid of remedies. These anti-assignment provisions prevent secured lenders from perfecting a security interest in the deposit accounts related to Medicare health-care-insurance receivables as original collateral and necessitate the use of a double lockbox arrangement to secure even identifiable cash proceeds in debtor deposit accounts.

B. Anti-Assignment Provisions of the Medicare Statutes Affecting Health-Care-Insurance Receivables

The Medicare statutes contain anti-assignment provisions prohibiting Medicare payments from going directly to persons other than health care service providers. In 1972, Congress enacted these anti-assignment provisions in an effort to eliminate a practice known as factoring. Factoring agencies purchase Medicare accounts receivables

34. NORTH CAROLINA UNIFORM COMMERCIAL CODE ANNOTATED WITH COMMENTARY 1 (Lexis Publishing, 2000) (quoting JULIAN B. MCDONNELL, UNIFORM COMMERCIAL CODE ANALYSIS OF REVISED ARTICLE 9 (Matthew Bender 1999)).

35. See infra notes 57-62 and accompanying text.

36. See infra notes 73-77 and accompanying text.

37. See generally Delilah Brummet Flaum and Marc L. Klyman, Health Care Securitization: Structuring Issues and Future Trends (2000), at http://www.securitization.net/knowledge/transactions/flaum_healthcare_clr. A double lockbox arrangement is one in which accounts receivables are paid into a deposit account belonging to the debtor (Lockbox 1) from which funds are swept on a daily basis into an account belonging to the lender (Lockbox 2). Id.

38. See infra notes 78-87 and accompanying text.


40. See 42 U.S.C. § 1396a(a)(32) (2000); see also 42 C.F.R. § 424.73 (2004). It is permissible for the health care provider to appoint a third party representative to receive Medicare payments for administrative billing purposes only. 42 C.F.R. § 424.73. This is not considered an assignment of Medicare payments to the third party. 42 C.F.R. § 424.73; see also Medicare Claims Manual, supra note 8.

41. See Gregory R. Salathe, Reducing Healthcare Costs Through Hospital Accounts Receivable Securitization, 80 VA. L. REV. 549, 562 (1994) (discussing the practice of factoring and the legislative history underlying the enactment of the Medicare and Medicaid
from health care providers and then serve as collection agents with respect to those claims. Congress believed that this practice led to over-inflation of claims and fraudulent behavior as factoring agencies billed patients for services not rendered or included excessive premiums in patient bills. According to the Medicare Claims Processing Manual, a health care provider's deposit account into which Medicare payments are made must be in the name of that provider. Only that provider is allowed to give instructions with respect to the deposit account, unless a court order has been entered directing Medicare payments to be made to a lender. The court order mandating the assignment must be filed with Medicare and may apply either to all Medicare payments due to a provider or to a specific amount of money payable to that provider.

The multiple federal restrictions on assigning Medicare health-care-insurance receivables to third parties places a tremendous obstacle in the path of a borrower attempting to leverage its health-care-insurance receivables in a secured lending transaction. Lenders who find it difficult to perfect their security interests in a debtor's Medicare receivables deposit account, or exercise remedies associated with a


42. See Salathe, supra note 41, at 562.
43. Id.
44. Medicare Claims Manual, supra note 8.
45. Id.
46. Id. (stating that the depositary “bank shall be bound by only the provider’s instructions” and “no other agreement that the provider has with a third party shall have any influence on the account”); see also 42 C.F.R. § 424.73(a) (2004).
47. See 42 C.F.R. §§ 424.73(a)(2), 424.90 (2004); Medicare Claims Manual, supra note 8; see also infra notes 121-148 and accompanying text.
48. 42 C.F.R. § 424.90(a) (2004); see also 42 C.F.R. § 424.90(c) (2004). Secured lenders should note that once they obtain a court ordered assignment of Medicare payments, the secured lender and the provider are then jointly and severally liable for any overpayments made to the secured lender. 42 C.F.R. § 424.90(c). Thus, if the secured lender is awarded a court ordered assignment of payments, the secured lender may wish to consider its liability in the event of overpayments made directly to the lender by Medicare. Setting aside a certain percentage of the Medicare receivables in a reserve account is one way for the secured lender to accommodate for erroneous Medicare payments.
49. See Salathe, supra note 41, at 549-76 (discussing the negative implications that the anti-assignment provisions are having on asset securitization).
50. See infra Part III.C.
perfected security interest in Medicare receivables,\textsuperscript{51} may be reluctant to include Medicare receivables in a health care provider’s borrowing base, reducing the amount of financing the health care provider can borrow.\textsuperscript{52}

III. PRACTICAL IMPLICATIONS FOR LENDERS AND THEIR COUNSEL IN DEALING WITH SECURITY INTERESTS IN MEDICARE HEALTH-CARE-INSURANCE RECEIVABLES AND THE RELATED DEPOSIT ACCOUNTS

A. Limited Rights Afforded by Financing Statement

Upon attachment\textsuperscript{53} and the proper filing of a financing statement,\textsuperscript{54} the secured lender will have a perfected security interest in the health-care-insurance receivables,\textsuperscript{55} which, in the case of non-Medicare health-care-insurance receivables, gives the secured lender a right to notify account debtors to make payments to the secured lender in the event of debtor default.\textsuperscript{56} In order to contrast the rights and remedies accompanying a perfected security interest in non-Medicare health-care-insurance receivables to those associated with Medicare health-care-insurance receivables, assume a secured lender files a financing statement indicating “health-care-insurance receivables from Blue Cross Blue Shield (BCBS)” as the collateral.\textsuperscript{57} The debtor defaults on the loan, triggering the secured lender’s ability to receive payments directly from BCBS.\textsuperscript{58} Any restrictions on the assignment of health-care-insurance receivables in the provider agreement between BCBS

\textsuperscript{51} See infra notes 57-62 and accompanying text.
\textsuperscript{52} See infra notes 155-57 and accompanying text.
\textsuperscript{53} U.C.C. § 9-203 (2001) (discussing when a security interest attaches to the pledged collateral).
\textsuperscript{54} U.C.C. § 9-502 (2001) (specifying that a financing statement must contain the name of both the debtor and the secured party and an indication of the collateral in order to be effective); see also, U.C.C. § 9-501 (2001) (instructing as to where the filing of a financing statement should be made); U.C.C. § 9-310 (specifying when a filing is required for perfection). But see U.C.C. § 9-309 cmt. 5 (2001) (stating that when an individual assigns a payment under a health-care-insurance receivable to a provider, the provider’s security interest in that receivable is perfected upon attachment).
\textsuperscript{55} Supra note 18 and accompanying text.
\textsuperscript{56} U.C.C. §§ 9-607(a) (2001) (giving the secured lender the right to receive payments directly from the account debtor, upon the event of debtor default).
and the debtor will be deemed ineffective under the UCC. In this scenario, the secured lender assumes the debtor’s position and receives health-care-insurance payments directly from BCBS.

In contrast, where health-care-insurance receivables are payable by Medicare, the anti-assignment provisions clearly prohibit secured lenders from stepping into the shoes of debtors in order to receive payments directly from Medicare. The secured lender will not be entitled to assume the debtor’s position in order to enforce the secured lender’s security interest with respect to the Medicare health-care-insurance receivables. The UCC drafters understood that restrictions on assignments are generally upheld where federal laws, such as the Medicare statutes, are concerned. Because the Medicare statutes are federal law and the UCC represents state law, the doctrine of preemption dictates that the federal law will control. In recognition of this fact, the drafters of the revisions to the UCC included a comment that perhaps the UCC’s views on eliminating anti-assignment provisions could become a template for future federal legislative action.

B. The Double Lockbox Strategy for Deposit Accounts

Lacking the ability to exercise remedies normally associated with a perfected security interest in Medicare health-care-insurance receivables, a secured lender should explore its ability to perfect a security interest in deposit accounts into which the debtor deposits payments received from Medicare. Presumably, once the debtor receives payment from Medicare, those funds will be deposited with the

60. See U.C.C. § 9-607(a)(1) (2001) (giving the secured party the right to notify the “account debtor,” in this example, BCBS, and demand that future payments be made directly to the secured lender, bypassing the debtor).
62. U.C.C. §§ 9-408(d)(4), 9-408(d)(6) (2001) (establishing situations in which anti-assignment provisions are not restricted, such as where there is a conflict between the UCC and federal law).
63. See infra text accompanying note 65.
64. See BLACK’S LAW DICTIONARY 1197 (7th ed. 1999) (defining preemption as the Constitutional “principle (derived from the Supremacy Clause) that a federal law can supersede or supplant any inconsistent state law or regulation”).
debtor’s depositary bank into a deposit account. Control is the only UCC mechanism for perfection of a security interest in deposit accounts as original collateral.

In the case of a deposit account for non-Medicare health-care-insurance receivables, control can be achieved through the execution of a deposit account control agreement. This agreement – between the secured lender, the debtor, and the depositary bank – provides that the receivables are deposited into a deposit account, which may be in the name of the debtor, the secured lender, or both. The important element of control exists in these arrangements even though the debtor may still have access to the funds in the deposit account. The secured lender will be deemed in control of the deposit account if the depositary bank agrees to take instructions from the secured lender “without further consent by the debtor.” The secured lender has a perfected security interest in all funds deposited into the deposit account at all times.

In the case of Medicare health-care-insurance receivables, the debtor will likely direct Medicare to deposit the payments into a deposit account. Unlike the typical arrangement where the depositary bank honors the instructions of the secured lender without further consent from the debtor, the deposit account control agreement would specify that, in the case of Medicare health-care-insurance receivables, the debtor retains the ultimate right to direct the disposition of funds in the deposit account. Ultimately, the secured lender does not have control

66. See supra note 32 and accompanying text.
68. U.C.C. § 9-104(a)(2) (2001) (describing a deposit account control agreement as an agreement between the debtor, the secured lender, and the depositary bank whereby the secured lender controls the deposit account through its ability to direct the depositary bank to take action with respect to the deposit account without the further consent of or instruction by the debtor).
69. Id.
70. U.C.C. § 9-104 cmt. 3 (2001) (stating that control is still present, even though the debtor may have access to the funds in the deposit account).
72. See supra note 67 and accompanying text.
74. See 42 C.F.R. §§ 424.73, 424.90 (2004); Medicare Claims Manual, supra note 8.
of the debtor’s Medicare receivables deposit account,75 which is the necessary element for perfecting the secured lender’s interest in the debtor’s Medicare receivables deposit account as original collateral.76 If the debtor declares bankruptcy, the lender will be relegated to the position of an unsecured lender with respect to the Medicare receivables deposit account collateral.77 Thus, with respect to Medicare health-care-insurance receivables, the secured lender must find a way to secure its interest in the debtor’s Medicare receivables deposit account that does not involve control of the account.

If the secured lender has a perfected security interest in the Medicare health-care-insurance receivables themselves,78 then the secured lender is automatically perfected in the identifiable cash proceeds of the Medicare health-care-insurance receivables.79 Thus, once Medicare makes a payment to a provider and that payment is deposited into the designated account of the provider/debtor, the secured lender’s security interest is perfected in the cash proceeds, even though the secured lender lacks control of the deposit account.80

In order to move the payments to the secured lender’s account, funds are swept at regular intervals from the debtor’s deposit account into an account belonging to the secured lender.81 This arrangement, in which initial payments go into the debtor’s deposit account and then flow into the secured lender’s account, is known as a double lockbox arrangement.82 This seems to be a clever way to bypass the Medicare anti-assignment provisions; yet, unfortunately for the secured lender, the debtor, which remains in control of its deposit account, can rescind the sweep order at any time, and the depositary bank must comply.83

75. 42 C.F.R. §§ 424.73, 424.90, (2004); Medicare Claims Manual, supra note 8.
77. See Black’s Law Dictionary 376 (7th ed. 1999) (defining an unsecured creditor as one who “takes no rights against specific property of the debtor”).
78. See supra notes 53-55 and accompanying text.
80. Id.
81. See Flaum & Klyman, supra note 37. The account into which funds are swept is commonly referred to as a lockbox account. Id.
82. Id.
Secured lenders should insist upon a daily sweep\textsuperscript{84} of the debtor's deposit account, but must realize that the debtor may divert funds from the account before the sweep.\textsuperscript{85} Additionally, if funds become trapped in the account in the event of debtor bankruptcy,\textsuperscript{86} enforcement problems will arise for the secured lender.\textsuperscript{87}

If the debtor, secured lender, and depositary bank agree to allow the secured lender to control the deposit account, contrary to the Medicare anti-assignment provisions, the ramifications to the provider/debtor could be severe.\textsuperscript{88} The Medicare statutes state that the provider agreement between Medicare and the health care provider/debtor may be terminated if the provider/debtor "enters into or continues any . . . arrangement, that authorizes or permits payment contrary to the provisions of" the relevant Medicare statutes.\textsuperscript{89} Because Medicare payments account for a significant portion of many health care providers' receivables,\textsuperscript{90} a health care provider/debtor, in evaluating his or her need for financing, must consider the risk of losing his or her provider arrangement with Medicare.

C. Third Party Legal Opinions: What a Lender can Reasonably Expect from Borrower's Counsel

1. Legal Opinions Concerning Medicare Health-Care-Insurance Receivables

In a typical financing transaction, the secured lender requests a recission of a sweep order an event of default under the primary loan agreement. \textit{Id.} The possibility of acceleration of the entire loan amount may make debtors less likely to rescind a sweep order on a deposit account. \textit{Id.}

\textsuperscript{84} See generally Flaum & Klyman, \textit{supra} note 37.

\textsuperscript{85} See generally U.C.C. § 9-315 (2001). If cash proceeds move on to a third party, become commingled or otherwise become unidentifiable, the secured lender will lose its perfected security interest in those funds. \textit{Id.}

\textsuperscript{86} 11 U.S.C. § 362(a) (2000). When a debtor files for bankruptcy the court imposes an automatic stay on all collection attempts by creditors. \textit{Id.}

\textsuperscript{87} \textit{Id.; see also} Flaum & Klyman, \textit{supra} note 37 (discussing the negative impact that the automatic stay imposed by a bankruptcy filing can have on a secured lender's interest in a Medicare health-care-insurance receivables deposit account).

\textsuperscript{88} See infra notes 89-90 and accompanying text.

\textsuperscript{89} 42 C.F.R. § 424.74 (2004).

\textsuperscript{90} \textbf{Acute Care Hospitals}, \textit{supra} note 2, at 10. Government programs accounted for 58% of hospital care expenditures in 2001 totaling approximately $263,107,000,000. \textit{Id.} With the aging population, that number is expected to climb. \textit{Id.}
legal opinion from the debtor's outside counsel stating that the secured lender's security interest in the debtor's collateral is perfected. Though counsel may be in a position to give a perfection opinion with respect to Medicare health-care-insurance receivables, it is unlikely that debtor's counsel would be able to satisfy the secured lender's request for an opinion stating that the secured lender will have effective remedies to enforce its perfected security interest.

With respect to both Medicare and non-Medicare health-care-insurance receivables, if debtor's counsel is satisfied that the security interest has attached, and that the financing statement meets the form requirement and is properly filed, debtor's counsel will be able to render an opinion stating that the security interest in health-care-receivables has been perfected, along with the security interest in identifiable cash proceeds. Secured lenders must remember, however, that an opinion stating that the security interest in health-care-insurance receivables is perfected is not equivalent to an opinion that the secured lender will be able to exercise its UCC remedies in the event of the debtor's default.

A remedies opinion, on the other hand, is a statement by debtor's counsel that the agreement between the secured lender and the debtor is enforceable. In giving a remedies opinion, debtor's counsel...

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91. See generally The TriBar Opinion Committee, Special Report of the TriBar Opinion Committee: U.C.C. Security Interest Opinions - Revised Article 9, 58 Bus. Law. 1453, 1469 (2003) (describing a perfection opinion as a statement of the borrower's counsel that, in her professional judgment, the lender's security interest is perfected so as to prevail against a lien creditor).

92. See supra notes 56-62 and accompanying text.

93. See generally The TriBar Opinion Committee, supra note 91, at 1505 n.335 (describing certain necessary elements for an attachment opinion). See also U.C.C. § 9-203 (2001) (regarding attachment).


95. See generally The TriBar Opinion Committee, supra note 91, at 1473-74; see also U.C.C. § 9-315 (2001) (regarding perfection in identifiable cash proceeds).

96. See infra notes 97-100 and accompanying text.

97. See The TriBar Opinion Committee, supra note 95. See also John R. Miller, Third-Party Legal Opinions In Business Transactions, 2d Ed., Report of the Legal Opinion Committee of the Business Law Section of the N.C.B.A., 53 (2004) (reporting the standard content of a remedies opinion to be that "the agreement constitutes the legal, valid and binding obligation of the company, enforceable against the company in accordance with its terms").
should consider whether or not specified remedies will be available to the secured lender in the event of default by the debtor. The remedies opinion may require qualification, given that, in the event of a default by the debtor, the secured lender would be required to seek a court order before it is allowed to exercise its rights under the UCC, leaving the lender without an affirmative statement concerning the availability of remedies.

2. Legal Opinions Concerning Deposit Accounts as Original Collateral

With respect to opinions concerning a perfected security interest in the debtor's deposit account as original collateral, the opinion giver would determine whether or not the applicable standards for achieving control of the deposit account are met. A standard opinion on the perfection of a security interest in a deposit account, as original collateral, would state that the security interest in the deposit account will be perfected upon the execution and delivery by the debtor, secured lender, and depositary bank of a legally sufficient deposit account control agreement. Because the Medicare statutes prohibit the secured lender from having control of a deposit account into which Medicare payments will be directly deposited, the deposit account control agreement regarding these deposit accounts should contain language giving the debtor ultimate control of the deposit account. Consequently, debtor's counsel would not be in a position to opine that the lender has a perfected security interest in the debtor's Medicare receivables deposit account as original collateral, because the element of control would not be satisfied. Without control, the security interest in the debtor's deposit account would be carved out of the perfection opinion, leaving the secured lender without a legal opinion regarding its

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98. See Miller, supra note 97, at 54 (listing numerous due diligence matters that debtor’s counsel must consider before giving a remedies opinion).
99. Id. at 55.
100. See supra notes 56-62 and accompanying text; see also infra notes 138-42 and accompanying text.
101. See TriBar Opinion Committee, supra note 95, at 1476.
102. Miller, supra note 97, at 89.
104. See supra notes 73-77 and accompanying text.
105. See TriBar Opinion Committee, supra note 95, at 1476.
security interest in the debtor’s Medicare health-care-insurance receivables deposit account, as original collateral.\textsuperscript{106}

3. Legal Opinions Concerning Double Lockbox Arrangement

Without a remedies opinion relating to Medicare health-care-insurance receivables\textsuperscript{107} or a perfection opinion regarding the debtor’s deposit account as original collateral,\textsuperscript{108} the lender should ask debtor’s counsel for opinions regarding both the legality of the double lockbox arrangement\textsuperscript{109} and the enforceability of remedies provided in the related lockbox agreements.\textsuperscript{110} Such opinions may provide some assurance to the lender that its position is secure with respect to the cash proceeds of the Medicare health-care-insurance receivables.\textsuperscript{111} In order to give a legality opinion,\textsuperscript{112} debtor’s counsel would examine applicable laws, including the Medicare anti-assignment provisions,\textsuperscript{113} and would make a determination about whether or not the double lockbox arrangement violates any applicable laws.\textsuperscript{114} With respect to a remedies opinion,\textsuperscript{115} debtor’s counsel should determine whether or not the remedies associated with the lockbox agreement are available to the

\textsuperscript{106} The Committee on Legal Opinions, \textit{Guidelines for the Preparation of Closing Opinions}, 57 Bus. Law. 875, 878 (2002) (articulating the “Golden Rule” for asking for a particular third party legal opinion: the recipient should not ask the opinion giver to give an opinion that she herself would not give in a similar circumstance).

\textsuperscript{107} See supra notes 97-100 and accompanying text.

\textsuperscript{108} See supra note 106 and accompanying text.

\textsuperscript{109} See supra notes 81-82 and accompanying text.

\textsuperscript{110} Id.; see also Miller, supra note 97, at 66 (describing a practical realization exception to a remedies opinion as a statement by debtor’s counsel that “certain of the remedies provided under the terms of the Agreement may be further limited or rendered unenforceable by applicable law, but in our opinion such law does not... make the remedies afforded by the Agreement inadequate for the practical realization of the principal benefits purported to be provided thereby”).


\textsuperscript{112} See Miller supra note 97, at 72 (describing a legality opinion as a statement by debtor’s counsel that “the execution and delivery by the [debtor] of the Agreement, and performance by the [debtor] of its obligations therein, do not violate applicable provisions of statutory laws or regulations”).


\textsuperscript{114} See Miller, supra note 97, at 72-74 (discussing the many exceptions which debtor’s counsel can add to its “no violation of laws” opinion, such as exceptions for specialized laws, materiality qualifications, or limitations on future occurrences).

\textsuperscript{115} Supra note 97 and accompanying text.
secured lender in the event of default by the debtor. Like the remedies opinion regarding Medicare health-care-insurance receivables, the remedies opinion relating to the lockbox agreement will likely contain many qualifications to account for possible problems resulting from the debtor's actions prior to the daily sweep. As with any other legal opinion, legality and enforceability opinions as they relate to the double lockbox arrangement, may not provide the lender with ideal assurances. However, these opinions may be the only opinions that debtor's counsel is able to render in light of the remedies and perfection problems associated with Medicare health-care-insurance receivables and the related deposit accounts.

D. Judicial Remedies: Convincing the Courts to Honor the Terms of the Deal

If Medicare health-care-insurance receivables comprise collateral for a loan and the debtor defaults, the normal UCC remedies, such as receiving Medicare payments directly, are not available to a secured lender. In the event of debtor default, the secured lender must resort to the judicial remedy provided in the Medicare statutes in order to obtain assignment of Medicare payments. Medicare will honor a court order assigning the payment rights to a third party if that court order is issued by a court of competent jurisdiction and filed with Medicare.

In Missionary Baptist v. First National Bank the Fifth Circuit

116. Supra notes 97 and 112 and accompanying text.
117. See supra notes 97-100 and accompanying text.
118. See supra note 87 and accompanying text. Some examples of the problems which may arise with respect to the funds in the deposit account are (1) entrapment in the case of a bankruptcy filing and (2) commingled or otherwise unidentifiable funds. Id.
119. See supra notes 97 and 112 and accompanying text.
120. See supra Parts III.A. and B.; see also Miller, supra note 97, at 75 (discussing another common opinion known as the "No Governmental Consents or Approvals" opinion). The "No Governmental Consents or Approvals" opinion is also problematic for debtor's counsel to give considering that governmental consent, in the form of a court ordered assignment, is required in order for the lender to exercise its UCC remedies in the event of debtor default. Infra notes 138-42 and accompanying text.
121. See supra notes 57-62 and accompanying text.
124. Missionary Baptist Found. v. First Nat'l Bank, 796 F.2d 752 (5th Cir. 1986).
Court of Appeals examined the legislative history of the Medicare anti-assignment provisions before determining whether or not Medicare accounts receivables could be used to collateralize a loan. In this case, Wilson, acting as trustee in bankruptcy for the Missionary Baptist Foundation (MBF), argued that the Medicare anti-assignment provisions invalidated MBF’s pledge of Medicare accounts receivables to First National Bank (FNB) as collateral for a loan. The Fifth Circuit concluded that to construe the anti-assignment provisions strictly would be to circumvent the purpose of the Medicare program as a whole, which is to help the financially needy obtain health care. The court rested its findings on the language in the Medicare statutes, which provides that “nothing in this paragraph shall be construed... to preclude an agent of [the provider] from receiving any such payment.” By creating a loose comparison between the lender/debtor relationship and the agent/principle relationship, the Fifth Circuit was able to create an exception to the Medicare anti-assignment provisions and therefore held that FNB’s security interest was valid.

In Credit Recovery Systems, LLC v. Hieke, the District Court for the Eastern District of Virginia held that there was no authority for a court to validate a prior agreement to assign Medicare receivables. In Hieke, Credit Recovery Systems, LLC (CRS) sought to enforce an agreement pursuant to which Hieke assigned its Medicare receivables to CRS. Pursuant to a settlement with the government over fraudulent claims and overpayments, Hieke subsequently agreed to waive any payments from Medicare, which was inconsistent with its assignment of Medicare payments to CRS. CRS brought the action asking the

125. Id. at 757.
126. Id. at 756.
127. Id. at 755-56.
128. Id. at 757-58.
130. Missionary Baptist Found., 796 F.2d, at 758 (emphasis added).
131. Id. at 759.
133. Id. at 696.
134. Id. at 691.
135. Id.
136. Id. at 691-92.
court to validate the assignment agreement with Hieke.\textsuperscript{137}

In \textit{Hieke}, the government, which joined the suit as an intervenor,\textsuperscript{138} argued that the assignment of Medicare receivables was invalid under Medicare statutes, and the court held that the plain language of the Medicare statutes prohibited assignments of Medicare receivables without a court order.\textsuperscript{139} Upon examining the Medicare provisions regarding assignment pursuant to a valid court order,\textsuperscript{140} the court held that such an order must be entered contemporaneously with and not after the assignment in order to validate an existing assignment.\textsuperscript{141} The court reasoned that “the statute pertaining to the assignment of Medicaid and Medicare receivables creates a strong presumption against assignment.”\textsuperscript{142}

In \textit{Hieke}, the court held that the pledge of Medicare receivables as collateral for a loan does not “run afoul of any of the federal rules relating to the assignment of Medicare and Medicaid claims.”\textsuperscript{143} In essence, a debtor may pledge its Medicare health-care-insurance receivables as collateral for a loan,\textsuperscript{144} but the secured lender may not depend on the availability of those receivables should the debtor default.\textsuperscript{145} Using Medicare receivables as collateral for a loan may be permissible under the Medicare statutes; however, secured lenders may not wish to secure their loan with the mere possibility of a court ordered assignment.\textsuperscript{146} The secured lender’s inability to exercise the remedies typically afforded by a perfected security interest in health-care-insurance receivables,\textsuperscript{147} independent of a court-ordered assignment, and

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  \item \textsuperscript{137} Credit Recovery Sys., LLC v. Hieke, 158 F. Supp. 2d 689, 692 (E.D.Va. 2001).
  \item \textsuperscript{138} Id.; see also BLACK’S LAW DICTIONARY 826 (7th ed. 1999) (defining an intervenor as “one who voluntarily enters a pending lawsuit because of a personal stake” in the outcome of the dispute).
  \item \textsuperscript{139} Hieke, 158 F. Supp. 2d, at 696.
  \item \textsuperscript{140} Id. at 694-95; see also 42 C.F.R. § 424.90 (2004).
  \item \textsuperscript{141} Hieke, 158 F. Supp. 2d, at 696.
  \item \textsuperscript{142} Id. (emphasis added).
  \item \textsuperscript{143} Credit Recovery Sys., LLC v. Hieke, 158 F. Supp. 2d 689, 693 (E.D.Va. 2001).
  \item \textsuperscript{144} Id.
  \item \textsuperscript{145} See supra notes 57-62 and accompanying text.
  \item \textsuperscript{146} See generally Hieke, 158 F. Supp. 2d, at 689-97. The overall affect of the anti-assignment provisions, mitigated only by a court-ordered assignment, seems to encourage litigation. While the remedy of a court ordered assignment is available, lenders and their counsel may be understandably reluctant to enter into a transaction in which litigation may be the first and only remedy if a default occurs.
  \item \textsuperscript{147} Id. at 696. The court in \textit{Hieke} does not address whether or not CRS had a perfected security interest in the Medicare receivables. Id.
the difficulty and uncertainty associated with the related deposit accounts, should cause secured lenders and their counsel to reconsider their decision to accept Medicare receivables as collateral.

E. Limiting Medicare Health-Care-Insurance Receivables in the Borrowing Base

Because a secured lender may never have a meaningful security interest in Medicare health-care-insurance receivables and the related deposit accounts, the secured lender must determine whether or not to include the amount of these receivables in the debtor’s borrowing base. The borrowing base is the total value of debtor assets that will be used to secure the loan. The loan amount will typically increase and decrease proportionately with the value of collateral in the borrowing base. Thus, exclusion from the borrowing base of a significant asset, such as Medicare health-care-insurance receivables, should severely decrease the amount a debtor can borrow.

A secured lender considers several factors in deciding whether or not to include Medicare health-care-insurance receivables in the debtor’s borrowing base: (1) credit-worthiness of the debtor, (2) value

148. See supra notes 75-77 and accompanying text.
149. See supra notes 57-62 and 73-77 and accompanying text.
151. See Colin Cross, Expanding the Borrowing Base with a Tranche B Loan, Fleet Capital CapitalEyes (2003), at http://www.fleetcapital.com/resources/capeyes. In asset-based lending, the lender considers the liquidation value of the assets in determining the borrowing base and includes a safety net of as much as 20% of the loan. Id. Thus, in order to secure a $1,000,000 loan, a borrower in an asset-based lending arrangement would need at least approximately $1,200,000 in assets to secure the loan. Id.; see also Kreft & Allweiss, supra note 150. Typical collateral included in an asset-based lending borrowing base are accounts receivables, equipment, inventory, and fixed assets. Kreft & Allweiss, supra note 150.
152. See Robert Rubino, Tried, True and Trusted - A Primer on Asset-Based Loans, Fleet Capital CapitalEyes (2002), at http://www.fleetcapital.com/resources/capeyes; see also Cross, supra note 151; Kreft & Allweiss, supra note 150.
153. ACUTE CARE HOSPITALS, supra note 2, at 1. "Medicare is the single largest payor for hospital care, covering $135 billion or 30% of hospital care expenditures in 2001. Medicaid paid for an additional $77 billion or 17% of hospital care expenditures in 2001.” Id.
154. Salathe, supra note 41, at 549.
of assets in liquidation, (3) appreciation and depreciation rates for assets, (4) requested loan amount, (5) costs associated with liquidation or foreclosure, and (6) the secured lender’s familiarity with health care financing in general. The secured lender may ultimately base its decision on the level of difficulty associated with collecting on or perfecting a security interest in these assets. The difficulties and uncertainties associated with collection place Medicare health-care-insurance receivables in that category of assets which lenders may, with good reason, either limit or exclude all together from the borrowing base.

IV. THE FUTURE OF HEALTH CARE FINANCING: HOW WILL HEALTH CARE PROVIDERS OBTAIN FINANCING?

Since secured lenders cannot exercise remedies under the UCC with respect to perfected security interests in Medicare health-care-insurance receivables, and cannot easily secure their position in the related deposit accounts, health care providers may need to find alternative means of financing their operations. One possible solution could involve using private health-care-insurance receivables as collateral for a loan, ignoring Medicare receivables in the borrowing base equation altogether. This seemingly simple solution would be detrimental to all Medicare providers and also raises several public

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155. See generally Cross, supra note 151.

156. Id. (claiming that “assets are often excluded because a lender determines that it would be difficult to collect or perfect its lien on them”).

157. See Nomura Sec. Int’l, Healthcare ABS Primer, NOMURA FIXED INCOME RESEARCH, at 6 (2002) (suggesting that lenders diversify the assets in the debtor’s borrowing base, possibly capping the percentage of Medicare receivables that are included).

158. ACUTE CARE HOSPITALS, supra note 2, at 18-23. Securitization, public debt and equity issuances, municipal bond issuance for non-profit hospitals, mergers, acquisitions and development campaigns are all alternative means for dealing with lack of access to traditional commercial based financing. Id.

159. See generally Cross, supra note 151 (discussing the possibility of junior secured financing to fill in the gap between the maximum amount that a senior lender is willing to provide and the financial needs of the borrower). These types of loans generally carry a greater risk and consequently a greater potential return for the junior lender. Id. As with all asset-based loans, the junior lender will still need to evaluate the liquidation value of the asset in its determination of the provider/debtor’s borrowing base. Id.

policy concerns. Hospitals located in areas where the population is predominantly poorer or older may have a disproportionately higher ratio of Medicare health-care-insurance receivables as compared to their receivables as a whole. On the other hand, suburban hospitals with wealthier clientele may have a much higher percentage of non-Medicare health-care-insurance receivables which they can more easily leverage. Another factor to consider is that provider participation in Medicare is voluntary. If providers found it overly difficult to leverage their Medicare health-care-insurance receivables in order to obtain necessary financing, those providers could reduce the number of Medicare patients who they see or refuse to see Medicare patients at all. This would obviously have dire consequences for the entire population and would be in direct contravention to Congressional goal of providing healthcare to the poor and the elderly through Medicare.

For many health care providers, the last option to accessing much needed financing may mean turning to questionable lenders ready to take advantage of the situation. In the fall of 2002, one such lender, National Century Financial Enterprises, Inc. (NCFE), declared bankruptcy, taking down with it several of its health care borrowers and many investors. Prior to its demise, NCFE was one of the largest health care finance companies in the nation, and was the primary source

$550 billion); Nomura Sec. Int'l, supra note 157, at 2.
161. See infra notes 162-66 and accompanying text.
162. See supra note 160.
163. ACUTE CARE HOSPITALS, supra note 2, at 5 (noting that financially weak hospitals are getting weaker while well capitalized hospitals are getting stronger).
165. See supra notes 162-64 and accompanying text.
166. Supra notes 5 and 128 and accompanying text.
167. Robert O’Harrow, Jr. & Bill Brubaker, FBI Raids National Century Offices, WASH. POST, Nov.17, 2002, at A12 (reporting that health care provider borrowers were required to pay larger than average fees and interest rates, and in some cases were required to give up control of their equity, in order to procure the funds needed to continue their operations).
of financing for most of its health care provider clients.\textsuperscript{170} NCFE provided desperately needed cash to health care borrowers in exchange for the rights to their health-care-insurance receivables, including payments due under Medicare.\textsuperscript{171} NCFE then packaged those receivables into bonds which it sold to investors in a practice known as securitization.\textsuperscript{172} The scheme began to unravel as NCFE loaned money based on future receivables and the debt load became more than many borrowers could pay.\textsuperscript{173} This questionable lending resulted in a downgrade in NCFE's bond ratings, which caused frightened investors to pull their funds.\textsuperscript{174}

In the wake of the NCFE collapse, many health care providers have also declared bankruptcy, and several others are struggling for funding.\textsuperscript{175} One such provider operating a hospital in one of the poorest areas of Washington, D.C. is feeling the effects of the lack of funding and has experienced an inability to care for as many patients, a reduction in its workforce, and overcrowding in its emergency room.\textsuperscript{176} NCFE provided financing to borrowers, in exchange for collateral, who could not have otherwise accessed financing from more traditional lenders. Given the difficulties inherent in perfecting a security interest in health-care-insurance receivables,\textsuperscript{177} it is difficult to imagine that traditional lenders will be willing to step in now and pick up the pieces.

\begin{footnotes}
\item[175] O'Neal, \textit{supra} note 170.
\item[176] Id.
\item[177] \textit{See supra} notes 57-62 and accompanying text.
\end{footnotes}
for a financially unstable health care industry.\endnote{178}

V. CHANGING THE MEDICARE STATUTES

The federal government could prevent both the practice of secured lenders excluding Medicare receivables from the provider/debtor's borrowing base and the healthcare industry's reliance on questionable financing arrangements by eliminating the outdated anti-assignment provisions of the Medicare statutes.\endnote{179} The anti-assignment provisions, enacted to curb the abuses of factoring agencies,\endnote{180} are no longer necessary in the world of modern lending practices.\endnote{181} The courts have long recognized that the Medicare statutes aimed to promote public health and welfare\endnote{182} and that the anti-assignment provisions, on their face, are on some level out of step with this purpose.\endnote{183} Thus, courts have been loosely interpreting the anti-assignment provisions in cases such as Missionary Baptist\endnote{184} while strictly interpreting them in decisions like Hieke.\endnote{185} This inconsistency between the purpose of the Medicare program as a whole,\endnote{186} the anti-assignment provisions in Medicare,\endnote{187} and the courts' interpretations of the anti-assignment provisions\endnote{188} must be resolved.

Creative lenders and lawyers are already structuring transactions to leverage Medicare health-care-insurance receivables, for example, by

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        \item See supra notes 2-3 and accompanying text.
        \item Salathe, supra note 41, at 563-64.
        \item See supra notes 41-44 and accompanying text.
        \item Salathe, supra note 41, at 563-64 (enumerating reasons why the practice of factoring should not be a concern in asset securitization and suggesting amendments to the Medicare and Medicaid anti-assignment provisions). In the practice of factoring a non-provider is charged with collection, whereas in asset securitization the provider continues to maintain responsibility for collecting payments. \textit{Id.} at 563. Also in asset securitization the expected Medicare accounts receivables are well-documented eliminating the concern over subsequently inflated charges which are the primary abuse in the factoring practice. \textit{Id.} Lastly, the quality of the typical asset securitization lender is high and fraudulent behavior by such a party is deemed unlikely. \textit{Id.}
        \item Missionary Baptist Found. v. First Nat'l Bank, 796 F.2d 752, 757-58 (5th Cir. 1986).
        \item \textit{Id.}
        \item \textit{Id.} at 759 (holding that assignment of Medicare receivables is permissible).
        \item Credit Recovery Sys., LLC v. Hieke, 158 F. Supp. 2d 689, 696 (E.D.Va. 2001) (holding that assignment of Medicare receivables is not permissible without a court order).
        \item See supra note 182 and accompanying text.
        \item See supra notes 39-48 and accompanying text.
        \item See supra notes 184-85 and text accompanying notes 121-48.
    \end{itemize}
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using double lockbox arrangements. Legitimizing the use of Medicare health-care-insurance receivables as collateral by eliminating the anti-assignment provisions may give even the most cautious of lenders an incentive to step into the health care financing market. Permitting secured lenders to exercise remedies associated with a perfected security interest in health-care-insurance receivables and to control a provider/debtor's Medicare deposit account would bring to the health care sector the kinds of financing options needed to revitalize the industry.

If eliminating the anti-assignment provisions is not feasible, then Congress could redraft the Medicare judicial remedies to allow courts to validate assignment orders after-the-fact. This would allow the secured lender and debtor to execute an assignment as a part of the original loan agreement. Default by the debtor would trigger the assignment, and the Medicare judicial proceeding would simply serve to validate the assignment, making the assignment of receivables payments a certainty rather than a mere possibility.

If Congress chooses not repeal or modify the anti-assignment provisions, lenders may consider placing a cap on the percentage of Medicare health-care-insurance receivables they will accept as collateral as compared to the overall borrowing base value from health care provider/debtors. Capping would enable providers to leverage a portion of their Medicare health-care insurance receivables while providing secured lenders with a portion of collateral not considered to be problematic. This option falls far short of eliminating the anti-assignment provisions and allowing for the unrestricted use of Medicare health-care-insurance receivables as collateral and raises the same

189. See generally Flaum & Klyman, supra note 37; Spradling, supra note 83; Nomura Sec. Int'l, supra note 157.
190. See Nomura Sec. Int'l, supra note 157, at 5.
191. See supra notes 57-62 and accompanying text.
192. See supra notes 73-77 and accompanying text.
193. See generally Ousley, supra note 4.
195. Id.
196. Id.
197. Supra note 157 and accompanying text.
198. Id.
public policy considerations discussed in Part IV of this Note. If secured lenders are only willing to accept a certain percentage of Medicare health-care-insurance receivables as collateral, it is likely that all health care providers will be hurt and especially poorer hospitals who may be more Medicare dependent than wealthier facilities.

VI. CONCLUSION

Current Medicare anti-assignment provisions dictate a conservative approach by lenders and their counsel which may result in limiting or excluding significant receivables assets from a debtor’s borrowing base. Leaving these valuable assets on the table is making an already depressed health care financing market even more vulnerable to financial distress. The most unfortunate result is poor patient care and outdated medical facilities.

Patients pay the highest price for the disconnect between the UCC and the Medicare statutes. Whether by lack of access or higher medical costs, we will all eventually feel the effects. Changing the Medicare statutes to clearly allow secured lenders to perfect their security interests and exercise their rights pursuant to valid security interests in Medicare health-care-insurance receivables will help provide health care facilities with the funds needed to better serve us all. By endowing Medicare health-care-insurance receivables with the normal remedies afforded under the UCC, Congress can provide adequate protection to financial institutions, which in turn will provide the funds needed to revitalize the health care industry and improve patient care.

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199. Supra notes 158-66 and accompanying text.
200. Id.
201. See supra notes 149-57 and accompanying text.
202. See supra notes 2-4 and accompanying text.
203. See supra note 122 and accompanying text.