

Les Jeux Ne Sont Pas Faits: The Right to Dignified Long-Term Care in the Face of Industry-Wide Financial Failure

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LES JEUX NE SONT PAS FAITS: THE RIGHT TO DIGNIFIED LONG-TERM CARE IN THE FACE OF INDUSTRY-WIDE FINANCIAL FAILURE

Nathalie D. Martin and Elizabeth Rourke***

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INTRODUCTION

The French have a common saying, “Les jeux sont faits.” In a legal context, it means “the political choice has been made.”¹ For example,

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¹ See Sophia Koukoulis-Spiliotopoulos, *From Formal to Substantive Gender Equality: Are International and Community Law Converging?*, 11 *REVUE EUROPEENNE DE DROIT PUB-*

with respect to equality between men and women, this phrase means that the decision to provide equal rights has been made and that's the way it is, regardless of how one feels about it. The issue is settled. By comparison, the rights of the elderly to receive dignified long-term care "jeux ne sont pas fait." The issue has not been decided. The political choice has not been made. The tough questions have not been answered, or perhaps even asked.

When Congress enacted the Balanced Budget Act of 1997 (the "BBA"),² which drastically reduced Medicare funds to nursing homes and home-health care providers,³ both industries began to fail.⁴ Ten percent of the nation's nursing homes are now operating in Chapter 11⁵ and over one-third of the nation's home-health care agencies in existence at the time the BBA was passed have closed their doors.⁶ While Congress and the United States General Accounting Office (collectively referred to herein as the "Government") have claimed that these budget cuts will not effect the care that people receive,⁷ the evidence already suggests other-

LIC EUROPEAN (REVIEW OF PUBLIC LAW) 515, 516 (1999); see also JEAN PAUL SARTRE, *LES JEUX SONT FAIT* (Nagel 1947).

² See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat 251 (1997) (codified as amended in scattered sections of 42 U.S.C.).

³ See *infra* Part II.A.

⁴ See M. William Salganik, *Golden Years Fade for Nursing Home Chains: An Industry Booming Only a Few Years Ago Struggles to Survive*, THE BALTIMORE SUN, Mar. 5th, 2000, at 1-D (reporting that 1,651 of the country's 17,000 nursing homes were operating under the supervision of the bankruptcy courts); Sandra Brown Kelly, *Home Health Care Companies Die En Masse: Medicare' Drive to Cut Costs Forces Many Companies to Go Belly Up*, ROANOKE TIMES & WORLD NEWS, April 26, 1999, at A1 (discussing home-health care agency failures). See also Karin Fischer, *Rural Health Agencies Hit Hard by Cuts*, CHARLESTON GAZETTE, July 5, 2000, at P1A (reporting that in West Virginia, 30% of the nursing homes in the state have filed for Chapter 11 bankruptcy); Ann Saphir, *Bankruptcies' Ripple Effect: Chapter 11 Filings Are Not Affecting Operations But Homes' Future Access To Capital Likely to Suffer*, MODERN HEALTHCARE, March 20, 2000. (reporting that in New Mexico 47% of homes are in bankruptcy, while in Colorado 24% are); *Texas Nursing Homes Say Low Medicare Rates Causing Crisis*, HOUSTON CHRONICLE, July 1, 2000, at 8P (reporting that in Texas, 22% of all nursing homes are now in bankruptcy).

⁵ See Saphir *supra* note 4.

⁶ See Richard Marini, *Bill Would Reduce Cuts in Medicare Reimbursement*, NurseWeek/HealthWeek (July 12, 1999), at <http://nurseweek.com/news/99-7/37a.html> (last visited April 7, 2001).

⁷ See *infra* Part II.B.; U. S. GEN. ACCOUNTING OFFICE, GAO-HEHS-99-120, *MEDICARE HOME HEALTH AGENCIES: CLOSURES CONTINUE, WITH LITTLE EVIDENCE THAT BENEFICIARY ACCESS IS DENIED* (1999) [hereinafter MAY 1999 GAO REPORT]; U.S. GEN. ACCOUNTING OFFICE, GAO-HEHS-00-23, *SKILLED NURSING FACILITIES: MEDICARE PAYMENT CHANGES REQUIRE PROVIDER ADJUSTMENTS BUT MAINTAIN ACCESS* (1999) [hereinafter DEC. 1999 GAO REPORT]; see also *Nursing Home Bankruptcies: What Caused Them? Hearings Before the U.S. Senate Special Comm. on Aging*, 106th Cong. (2000), <http://www.senate.gov/~aging/hr57.htm> (hereinafter *Nursing Home Bankruptcies*). Dr. Charles Roadman, II, President of the American Health Care Association stated,

I want to speak directly to recent assertions by the GAO that there is no crisis in long term care, that bankruptcies affecting close to 2,000 skilled nursing facilities is not

wise.⁸ Most people who have followed this legislation and its effects believe that the cuts have been a disaster⁹ and that there have been resulting human costs.¹⁰

The health-care portion of the BBA was enacted to eliminate profligate spending on the part of care providers, to eliminate waste for unnecessary services, and to eliminate the propensity for fraud in these industries.¹¹ While this legislation may have achieved one or more of these goals, it also has reduced both the availability of¹² and the quality

problematic, and that any difficulties confronting all providers are the direct result of business decisions Bankruptcies among skilled nursing facilities have reached an alarming figure of approximately 2,000 facilities in the last year alone. But, let me state very, very clearly, on the record, to everyone here today: This is just the tip of the iceberg. Our long term care community is facing a squeeze with the real potential for absolute collapse that will put at risk care for all SNF patients—We are faced with countless challenges affecting caregivers and patients alike My assessment is clear—the government’s commitment to fund quality care is wavering—Medicare funding for nursing facility care has been seriously cut, and Medicaid programs across the country are traditionally and, in some cases, grossly underfunded to the point of paying an average \$4 per hour for care in a nursing facility. Sadly, Mr. Chairman, this is less than we pay a teenage babysitter.

Id.

⁸ Ironically, Congress is now considering imposing mandatory federal staffing standards on the entire industry. See Robert Pear, *Nursing Home Crisis Targeted*, TIMES UNION (ALBANY), July 23, 2000, at A1. Of course, now that Medicare reimbursement rates are so low, most homes cannot afford to hire more staff. See *id.*; see also *Politics and Policy Nursing Homes: HHS Recommends Strict New Staffing Rules*, AMERICAN POLITICAL NETWORK: AMERICAN HEALTH LINE, July 24, 2000, at 5.

⁹ See *Nursing Home Bankruptcies*, *supra* note 7. Dr. Roadman stated, “[T]he typical [nursing home resident] puts the overall quality of his or her life in the hands of our profession. It’s our charge to provide quality medical care to improve their health and quality of life.” *Id.* He also said, “The current economic crisis threatens both current and future beneficiary access—without adequate reimbursement to meet operating and capital requirements, providers cannot survive.” *Id.*

¹⁰ See Nancy Peterman, *American Bankruptcy Institute: The Healthcare Industry Bankruptcy Workouts Forum*, 8 AM. BANKR. INST. L. REV. 5, 20 (2000) (discussing how the Balanced Budget Act is likely to create a shakeout similar to the real estate shakeout created by the 1986 tax reforms, but this time with real human costs); Editorial, *A Health Care Disaster in the Making, Federal Missteps: Cuts in Medicare Reimbursements are Strangling Medical-Delivery Systems*, THE BALTIMORE SUN, July 7, 2000, at A16 (stating that the cuts that balanced the budget have “lowered the quality of health care for millions of Americans—especially senior citizens—and have seriously eroded the viability of hospitals, nursing homes, home-health care companies and health plans for the elderly”).

¹¹ See DEC. 1999 GAO REPORT *supra* note 7 at 1; COMM. ON GOV’T REFORM & OVERSIGHT, *MEDICARE HOME HEALTH SERVICES: NO SURETY IN THE FIGHT AGAINST FRAUD AND WASTE*, H.R. REP. NO. 105-821, 5-12 (1998).

¹² See, e.g., Malia Rulan, *Cuts in Medicare Limit Care: Elderly, Disabled in W. Va. Affected*, CINCINNATI ENQUIRER, Feb. 21, 2000, at A02; see also Christopher Clark, *New Medicare Rules Pose Tough Choices*, LOS ANGELES TIMES, Feb. 21, 2000, at A19; Therese Smith Cox, *Medicare Cuts Bite into Home Health Care*, CHARLESTON DAILY MAIL, Oct. 12, 1999, at PIC.

of¹³ rehabilitation care to the nation's elderly. A small percentage of the cuts have been reversed in the past several months, in order to undo some of the unintended effects of the BBA,¹⁴ but this has by no means eliminated the harm. Long-term care industries have begged Congress to further reduce these cuts, going so far as engaging in a national TV campaign.¹⁵ So far Congress has not done so.¹⁶

The situation is both depressing and frightening, yet most of the American public has hardly noticed. When asked why so little public and media attention has been directed to this issue, one Elder Law student's comment was apt:

People don't want to hear about it. Aging is depressing; nursing homes are more so. And nursing homes in bankruptcy? That's just too much. The home-health care news is no better. You tell us about the stroke victim who had to choose, under the new Medicare reimbursement system, between therapy for walking and therapy for talking. I'm interested. When you then follow up with how he chose talking and then fell down from frailty and ended up dead, people don't want to hear about this guy, to think about him. Life is just too short.¹⁷

¹³ See Richard Teetsel, *Efforts to Improve Health Care Have Only Made Things Worse*, BUFFALO NEWS, Dec. 24, 1999, at C2. In Massachusetts, nursing home wages are sometimes lower than fast food wages. One nursing home owner reported that she was unable to keep good staff because she could not afford to pay them enough. See Karen Hsu, *Elder Advocates Say Poor Wages Affecting Care*, THE BOSTON GLOBE, Feb. 18, 2000, at B-1.

¹⁴ See, e.g., John E. Mulligan, *Medicare Give-Backs Pass in Budget Vote*, PROVIDENCE JOURNAL, Nov. 19, 1999, at A16. The budget cuts in the BBA created a Federal surplus, and many politicians have taken credit for that surplus. See *Remarks by the President to the Democratic Leadership Council: Conference on "New Challenges of the New Economy"*, M2 Press-wire, Apr. 5, 2000, available at 2000 WL 18095372.

¹⁵ See *Week in Healthcare: Inside the Beltway*, MODERN HEALTHCARE, July 24, 2000, at 8. This report notes that a coalition of hospital groups, pharmaceutical companies and health-care systems ran national television advertisements to encourage Congress to increase Medicare provider payments restrained under the BBA. According to the article, the ads are part of a \$30 million dollar campaign directed at influencing Congress and the next president about the dire financial conditions in these industries. See *id.*

¹⁶ After seeing the first effects of the BBA of 1997, Congress attempted to ameliorate some of these effects with the enactment of Balanced Budget Refinement Act of 1999. See Pub. L. No. 106-113, § 1000(a)(6), 113 Stat. 1501A-321 (1999). Under the BBA of 1999, further reductions in reimbursements were to take place in October of 2000. However, in July 2000, Congress acted to waive these cuts until 2001. See Mark Taylor, *Long-Term Care Reaps Billions from HCFA*, MODERN HEALTHCARE, July 31, 2000, at 6. These "givebacks," as well as other financial factors, are predicted to increase Medicare payments to skilled nursing facilities by as much as 20%. See *Medicare Will Increase Pay to Nursing Homes During Fiscal 2001*, WALL ST. J., July 26, 2000, at B2.

¹⁷ Interview between Nathalie Martin and anonymous Elder Law student, New Mexico School of Law, in Albuquerque, N.M. (Mar. 10, 2000).

This Article explores issues that we, as a society, would rather *not*, but *must*, discuss. These issues include aging, how the future costs of long-term care will be paid, and what form and quality of long-term care will continue to be financed through Medicare. More specifically, this Article discusses the philosophical issues raised by the cuts, as well as the practical implications of the cuts for patients and residents. It also attempts, primarily through information about the administrative and other costs of the federal bankruptcy process, to refute government claims that these cuts have not and will not affect patient care.

Part I of this Article describes the extent of the financial failure in the nursing home and home-health industries, briefly explains what funds were cut by the BBA, and briefly describes the Government's position with respect to the effects of the cuts.¹⁸ Because so many long-term care providers are now operating under Chapter 11 of the Bankruptcy Code, Part II describes the general Chapter 11 process, the difficulty of successfully reorganizing under Chapter 11, the high direct and indirect costs of all bankruptcy proceedings, and the risks that bankruptcy poses for patients and residents.¹⁹ Part III discusses other risks created by the cuts, particularly the unavailability of necessary care.²⁰ Part IV calls for a public discourse about our national policy with respect to both aging and funding long-term care with public funds.²¹ Ultimately this Article concludes that we left too much up to Congress, in expecting it to be able to address this complex and taboo issue. The legislation enacted by Congress in 1997, in order to balance the budget, was not well thought-out and has created risks to long-term care recipients that were neither contemplated nor condoned.²²

This Article ultimately recommends that in the very near future, policy-makers develop a long-term strategy with respect to which long-term care services will be funded through Medicare.²³ By fostering a public dialog to facilitate discussion of this issue, society can make real choices about health care, politicians can be made accountable for legislating this policy, and Congress can be forced to act in accordance with it.²⁴

¹⁸ See *infra* Part II.

¹⁹ See *infra* Part III.

²⁰ See *infra* Part IV.

²¹ See *infra* Part V.

²² See *infra* notes 127-28 and accompanying text.

²³ See *infra* notes 137-39 and accompanying text.

²⁴ See *infra* notes 152-61 and accompanying text.

I. THE BALANCED BUDGET ACT AND FINANCIAL FAILURE IN LONG-TERM CARE

Between September of 1999 and June of 2000, five of this country's largest nursing home chains filed for protection under Chapter 11 of the Bankruptcy Code.²⁵ On September 13, 1999, Vencor, Inc. of Atlanta, Georgia, which operates 293 nursing homes and 56 hospitals, filed for Chapter 11 protection.²⁶ On October 14, 1999, Vencor was joined by Sun Healthcare Systems of Albuquerque, New Mexico, which operates 369 homes and serves 40,000 people nationwide.²⁷ On January 18, 2000, a third large chain of nursing homes, Mariner Post-Acute Network, Inc., filed for bankruptcy.²⁸ Integrated Health Systems, Inc., the nation's fourth largest chain, filed for Chapter 11 in February of 2000,²⁹ and Genesis Health Services Corporation, the nation's fifth largest chain, followed suit in June of 2000.³⁰ Many stand-alone homes and smaller chains also have filed for Chapter 11 since the budget cuts went into effect.³¹ Thus, over 175,000 nursing home residents now live in a home that is in bankruptcy.³²

The home-health care industry has been affected to an even greater degree by the budget cuts, with over one-third of all agencies now closed,³³ and many remaining firms operating in bankruptcy.³⁴ The

²⁵ See *infra* notes 25-30 and accompanying text. Frontier Group, Inc., Lenox Health Care, Inc., and New Care Health Corp. have also filed for bankruptcy. See Dan Margolies & Julius Karrash, *Nursing Home Industry Staggers Under Filings: Bankruptcy Moved Blamed on Medicare Cuts, Debt, Scrutiny*, KANSAS CITY STATE, Feb. 5, 2000, at A1.

²⁶ See Scott Thurston, *Nursing Home Operator Seeks to Reorganize its Finances*, ATLANTA J. & CONST., Jan. 19, 2000, at D3.

²⁷ See Gayle Geis O'Dowd, *Creditors, Sun Craft Debt Deal*, ALBUQUERQUE J., Oct. 27, 1999, at A1.

²⁸ See Harold J. Adams, *Another Nursing Home Goes Bankrupt: Mariner Joins Sun Healthcare and Vencor*, COURIER-J. (Louisville, Ky.), Jan. 19, 2000, at 14B.

²⁹ See Bruce Jaspén, *Integrated Health in Chapter 11, Nursing Home Chain Blames Reductions in Medicare Spending Growth*, CHICAGO TRIB., Feb. 4, 2000, at A-1.

³⁰ See *Nursing Home Firm In Chapter 11*, ALBUQUERQUE J., June 24, 2000, at C1.

³¹ In February of 2000, Professor Martin began conducting empirical research about the number of nursing homes, outside the big four chains that had filed at that time, that were in bankruptcy. The research was conducted by sending a letter to most of the United States Bankruptcy Judges, asking them to identify any nursing homes that had filed in the past year. By March 30, 2000, over 60 judges had responded, reporting over 40 cases. Although the letter did not request information about home-healthcare bankruptcies (because we were unaware of the proliferation of such cases at the time the letter was sent), many judges reported having no nursing home cases but many home-healthcare agency cases.

³² There are over 177,000 beds in bankrupt nursing homes. See Salganik, *supra* note 4, at D1.

³³ See Andy Miller, *Medicare Cuts: Industry Taking a Big Hit: Home Health Care Agencies, Hospitals & Nursing Homes Are Still Reeling*, THE ATLANTA CONST., Oct. 31, 1999, at H1. There also has been a 40% decrease in revenues to home health care agencies, which has created a national crisis. See *id.* Many patients previously treated at home are receiving treatment in hospital emergency rooms now. See *id.*

³⁴ See Kelly, *supra* note 4, at A1.

BBA cut Medicare payments to home health care agencies by 15%, and according to some estimates, these cuts put as many as 50% of home health care agencies across the country out of business.³⁵ Lawmakers projected that the BBA would save \$10 billion in Medicare by cutting back on home health care services, but the savings have been more in the range of \$46 billion.³⁶

Ironically, only the wealthier failing businesses can even afford to file for bankruptcy, because the added administrative costs are so high.³⁷ The smallest and the most cash-poor home health care providers, and those most likely to provide services to the poor, have instead just closed their doors and disappeared.³⁸

A. WHAT THE BALANCED BUDGET ACT CUT

Before the BBA, Medicare reimbursed nursing homes and home-health care providers for all costs incurred in caring for patients.³⁹ Congress felt these reimbursement policies created the wrong incentives for homes and home-health care agencies, some of which may have been providing more care than was actually needed.⁴⁰ As a result, Congress enacted the BBA, a prospective reimbursement system that caps the amount a nursing home or home-care provider can be reimbursed for each particular patient.⁴¹ It also limits the number of rehabilitation visits each person can receive.

For example, starting in January of 1999, payments were capped at 80% of the lower of the actual charges or the amount paid, under a physi-

³⁵ See Harold J. Adams, Home-Health Industry Adjusts to Cuts: Some Shakeout Survivors Thrive Under New Rate, *COURIER-J.* (Louisville, Ky.), Feb. 7, 2000, at 1C.

³⁶ See Chris Meehan, *Abraham Aims to Halt Medicare Bleeding*, GRAND RAPIDS PRESS, Sept. 21, 1999, at B1.

³⁷ See Elizabeth Warren & Jay Lawrence Westbrook, *Financial Characteristics of Business Bankruptcy*, 73 *AM. BANKR. L.J.* 499, 500 (1999) (stating that most Chapter 11 cases are very small by the time that they are filed and that "it is unclear whether the vast majority of these debtors [can] support the complex Chapter 11 reorganization structure, even if they had viable businesses" and that "Chapter 11 may be too expensive for most of the businesses that file").

³⁸ Newspapers report that as of September of 1999, over 2,500 home-health care agencies have closed their doors. See Meehan, *supra* note 36, at B1. While some of the budget cuts have been reversed, in order to ameliorate some of the unplanned consequences of the BBA this has not protected home-health care providers from financial crisis. See Mulligan, *supra* note 14, at A19. For example, one of Florida's largest home-health care agencies, Flagship Healthcare, filed a petition under Chapter 7, despite the "give-backs." See *Business Today: Correction*, ST. PETERSBURG TIMES, Jan. 8, 2000, at 1E. Meanwhile, some people have died as a result of not receiving proper treatment. See Clark, *supra* note 14, at A19.

³⁹ See Chris Adams, *GAO Says Woes of Nursing-Home Firms Aren't Caused Only by Medicare Policy*, WALL STREET J., Dec. 27, 1999, at A20.

⁴⁰ See DEC. 1999 GAO REPORT, *supra* note 7 at 1.

⁴¹ See *id.* at 6.

cian fee schedule.⁴² Moreover, beginning on January 1, 1999, an annual per beneficiary limit of \$1,500 applies to all outpatient physical therapy services, except for services provided by hospital outpatient departments.⁴³ This interpretation requires patients to choose between physical therapy and speech therapy, even if both are needed. It purportedly has caused patients to put off receiving therapy, in order to “save” their benefits for more severe problems that could arise later in the year.⁴⁴

A separate \$1,500 per beneficiary limit applies to all outpatient occupational therapy services except for those services furnished by hospital outpatient departments.⁴⁵ The physical, speech, and occupational therapy caps are not subject to increase until 2002.⁴⁶ Although President Clinton signed an omnibus budget package that contained a two-year moratorium on the \$1,500 per person cap on November 29, 1999,⁴⁷ and the Health Care Finance Administration reduced some of the future cuts on July 26, 2000, effective as of October 2000,⁴⁸ the BBA has had a devastating effect on care for the elderly.⁴⁹ For example, the BBA reduced Vencor’s medical funding by \$200 million per year, but did not reduce the number of patients cared for by Vencor.⁵⁰ Sun Health Care reported that the Balanced Budget Act cut its revenues by more than \$700 million, without changing the quality of care that it was required to provide to residents.⁵¹ Similarly, home-health care providers’ budgets have been so drastically cut that care is now impossible to obtain in some areas.⁵²

⁴² See Balanced Budget Act of 1997, Pub. L. No. 105-33 § 4541, 111 Stat. 251, 455-456 (1997) (current version at 42 U.S.C. § 1395m (1994 & Supp. V. 1999)).

⁴³ See *id.* § 4541, 111 Stat. at 456-457 (current version at 42 U.S.C. § 1395I).

⁴⁴ See *id.*

⁴⁵ See *id.*

⁴⁶ See *id.*

⁴⁷ See Pub. L. No. 106-113, § 1000(a)(6), 113 Stat. 1501A-321 (1999).

⁴⁸ See Taylor, *supra* note 16, at 8.

⁴⁹ For example, Medicare payment cutbacks are projected to reduce spending at skilled nursing facilities by nearly twice as much as Congress expected; between 1998-2004, federal spending at these facilities is projected to be \$15.8 billion *less* than what Congress anticipated. See *Report: Cutbacks at Nursing Facilities Due to Balanced Budget Act*, CONGRESS DAILY, Aug. 9, 2000, 2000 WL 21160922 (emphasis added).

⁵⁰ See Andrew Wolfson, *Entrepreneur Reached Too Far, Too Fast: Local Hero's Star Faded Along With Vencor's*, COURIER-J. (Louisville, Ky.), Nov. 21, 1999, at 01A. The BBA cut daily reimbursements per patient by 20%. See *id.*

⁵¹ See *e.g.*, Chris Pope, *Sun Healthcare Files for Protection: Industry-Wide Problem Seen*, TELEGRAM & GAZETTE (Worcester, Mass.), Oct. 16, 1999, at B8; *Sun Healthcare Group Inc., Third-Quarter Loss Posted on New Rules for Medicare*, WALL ST. J., Dec. 8, 1999, at C30.

⁵² See Cox *supra* note 12, at PIC.

B. GOVERNMENT DENIAL OF CONNECTION BETWEEN INDUSTRY FAILURE AND THE BBA

Not long after the bankruptcy filings of the first two huge nursing home chains, the General Accounting Office (“GAO”) investigated the causes of the nursing home bankruptcies.⁵³ In a report that was released in December of 1999, the GAO essentially states that “[r]ecent changes in Medicare payments aren’t *entirely* to blame for the bankruptcy-court filings of two big nursing-home companies.”⁵⁴ The report states that their large total losses stem from high capital-related costs, reduced demand for ancillary services (caused by other portions of the BBA), and substantial nonrecurring expenses and write-offs reflecting reductions in future anticipated earnings.⁵⁵ Another cause, according to the GAO report, was the failure of nursing homes to react quickly enough to the changes in reimbursement policies.⁵⁶ Despite being called “other” causes, many of these conditions flow directly from the changes in the law.

Similarly, even though “one-third of home healthcare agencies operating when the BBA was passed are no longer in business,”⁵⁷ the GAO report relating to financial problems in this industry denies any connection between the cuts and the financial problems.⁵⁸ Yet there is little doubt that the BBA caused these agency closures and bankruptcies.⁵⁹

⁵³ See DEC. 1999 GAO REPORT, *supra* note 7.

⁵⁴ Chris Adams, *supra* note 39 at A20 (emphasis added). Of course this would have to be true, as all historic events have more than one cause. See also, DEC. 1999 GAO REPORT, *supra* note 7 at 13 (“Our analysis, however, suggests that the financial difficulties of Sun and Vencor are the result of several factors beyond the SNFs [skilled nursing facilities] PPS [prospective payment system].”).

⁵⁵ See DEC. 1999 GAO REPORT, *supra* note 7 at 3.

⁵⁶ See *id.*

⁵⁷ Marini, *supra* note 6. Some estimate that up to 40% of home health care providers have gone out of business. See Joseph M. Schifano & Paul Zucarelli, *Long-Term Care Insurance Can Save You a Bundle*, TUCSON CITIZEN, Apr. 10, 2000, at 9A.

⁵⁸ See DEC. 1999 GAO REPORT, *supra* note 7 at 13. The same report also claims that the closure of home health care agencies has not significantly affected the industry’s ability to provide services. See *id.* at 2. (Medicare beneficiaries’ ability to obtain needed care does not appear to have decreased since the implementation of the SNFs [skilled nursing facilities] PPS [prospective payment system].”).

⁵⁹ See Peterman, *supra* note 10, at 7. One member of the panel stated:

The home healthcare industry has seen somewhere between a quarter and a third of its businesses disappear since the Balanced Budget Act of 1997 came into effect. Many of those businesses have disappeared, we’ve seen from real life examples, because they simply couldn’t make money under the current reimbursement scheme.

II. WHAT IS CHAPTER 11 BANKRUPTCY AND WHAT ARE ITS EFFECTS ON PATIENT CARE?

Some scholars and bankruptcy lawyers would surely claim that bankruptcy, in and of itself, is not necessarily a bad thing. Bankruptcy, particularly Chapter 11 reorganization, can give a company "a critical respite from pressing financial difficulty."⁶⁰ No one would deny, however, that industry-wide bankruptcy indicates financial weakness in an industry. Thus, by all ordinary financial standards, the nursing home and the home-health care industries are very sick indeed. This weakened financial condition does not merely affect lenders and suppliers - patients and residents are also affected.

A. GENERAL BANKRUPTCY PRINCIPLES

Bankruptcy can prevent a failing business from going out of business.⁶¹ It creates an automatic stay of all collection activity that the debtor may be facing.⁶² It stops all lawsuits in their tracks, stops all other collection activities, and allows the debtor a "breathing spell" in order to work out its financial problems.⁶³ If the debtor files a Chapter 11 reorganization case,⁶⁴ rather than a Chapter 7 liquidation case,⁶⁵ the debtor will be permitted to continue operating its business⁶⁶ and to propose a reorganization plan upon which creditors will vote.⁶⁷ A typical Chapter 11 plan allows the debtor to pay creditors over time, often in a

⁶⁰ See David R. Korobkin, *The Unwarranted Case Against Corporate Reorganization: A Reply to Bradley and Rozenzweig*, 78 IOWA L. REV. 669, 734 (1993).

⁶¹ See 11 U.S.C. §§1101-1131 (1994 & Supp. V, 1999); see also Hope W. Olsson, *The RTC Intrusion Into Bankruptcy: A Crisis Solution at the Expense of Equity*, 42 BUFF. L. REV. 893, 914 (1994). According to this author,

The bankruptcy system is a vital part of the national economy The orderly administration of bankruptcies has played an essential role in the evolution of our market economy. Bankruptcy is a proven framework within which the economy deals equitably and predictably with financial crises of individual entities, and Chapter 11 is a powerful tool for the orderly reorganization of businesses experiencing financial difficulties.

See *id.*

⁶² See 11 U.S.C. §362; see also WEIL, GOTSHAL & MANGES, LLP, REORGANIZING FAILING BUSINESSES; A COMPREHENSIVE REVIEW AND ANALYSIS OF FINANCIAL RESTRUCTURING AND BUSINESS REORGANIZATION 5-2 to 5-4 (1998)[hereinafter REORGANIZING FAILING BUSINESSES]

⁶³ See 11 U.S.C. §362, REORGANIZING FAILING BUSINESSES, *supra* note 62, at 5-2 to 5-4 (describing the powers of the automatic stay).

⁶⁴ See *id.* §§ 1101-1131.

⁶⁵ See *id.* § 1129.

⁶⁶ See *id.* §§ 1101-1131; see also REORGANIZING FAILING BUSINESSES, *supra* note 62, at 5-1 ("Chapter 11 of the Bankruptcy Code provides a financially troubled business with an opportunity to restructure its finances to enable the continuation of its operations.").

⁶⁷ See D. M. LYNN, MICHAEL R. ROCHELLE, AND ROBERT J. MOTTERN, 1997 COLLIER HANDBOOK FOR TRUSTEES AND DEBTORS IN POSSESSION 26-6 (1997)[hereinafter COLLIER HANDBOOK](explaining the Chapter 11 voting process).

reduced amount.⁶⁸ Other typical Chapter 11 plans involve selling the equity in⁶⁹ or the assets of the company to a purchaser,⁷⁰ or distributing the company stock to shareholders in satisfaction of their claims.⁷¹

B. PREDICTORS OF A SUCCESSFUL REORGANIZATION

Many nursing home and home-health care employees, residents and families, want to know the practical ramifications of these bankruptcies on their facilities. Common questions include: 1) will the facility stay in business, 2) will patient and resident interests be protected, and 3) will staff lose their jobs? There are no easy answers to these questions. Unfortunately, most reorganization efforts fail for reasons explored in greater detail below.⁷² That does not mean that all of the nursing homes and home-health care agencies in Chapter 11 will close their doors. It does mean that eventually some will likely go out of business, displacing some nursing home residents.

Studies show that the best predictor for success in Chapter 11 is a company's size.⁷³ The bigger the debtor-company, the more likely that it will emerge from Chapter 11 operational, because it is better able to absorb the astronomical administrative fees that bankruptcy adds to regular monthly costs.⁷⁴ Larger companies can also sell off assets in order to raise operating capital.⁷⁵

Moreover, the shorter the bankruptcy case, the more likely it is that the home or agency will stay in business.⁷⁶ Additionally, the more planning that a company can do before filing for bankruptcy, the better the chances of emerging from bankruptcy.⁷⁷ However, it does not appear

⁶⁸ See *id.* at 26-9 (referring to this type of plan as an "extension" plan).

⁶⁹ See *id.*

⁷⁰ See REORGANIZING FAILING BUSINESSES, *supra* note 62, at 11-39 to 11-40 (describing plans involving sale of all or substantially all of the debtor's assets).

⁷¹ See COLLIER HANDBOOK, *supra* note 67, at 26-9 (referring to this type of plan as an "equity conversion" plan).

⁷² See *infra* Part III.C.; see also Theodore Eisenberg, *Bankruptcy in the Administrative States*, 50 LAW & CONTEMP. PROBS. 3, 17 (1987).

⁷³ See Donald A. Jordan, *Cross-Collateralization in Chapter 11: Protecting the Small Business*, 4 WAYNE L. REV. 219, 235 (1993).

⁷⁴ See Lynn M. LoPucki, *The Death of Liability*, 106 YALE L.J. 1, 50 (1996) (noting that reorganization costs can equal 21% of a small company's entire worth, compared to only 3% of a large company's worth).

⁷⁵ See REORGANIZING FAILING BUSINESSES, *supra* note 62, at 11-39.

⁷⁶ See *supra* notes 81-88; see also generally SOL STEIN, A FEAST FOR LAWYERS (1989) (explaining in a humorous way why Chapter 11 costs money, including the lack of incentive on the part of hourly-paid lawyers to help you wrap up your case).

⁷⁷ See REORGANIZING FAILING BUSINESSES, *supra* note 62, at 12-4 (noting that a long Chapter 11 case can have an adverse effect on operations); *id.* at 12-6 (noting that the costs of a pre-packaged Chapter 11 case, in which the repayment plan is more or less approved by the major creditors prior to filing for bankruptcy, are generally less than half as expensive as a traditional Chapter 11 case).

that there was much time for pre-bankruptcy planning before these nursing homes and home-health care providers filed for bankruptcy.⁷⁸ These industries have been financed for years based upon the old Medicare reimbursement system, which was changed with little notice or opportunity to restructure debt.⁷⁹

Will these cuts affect patient care or will they simply, as some attorneys insist, provide homes with leverage to negotiate with banks? Anecdotal conversations with the attorneys for lenders suggest that lenders think they are the only ones being hurt by the cuts. From their perspective, the bankruptcy cases will reduce bank debt, but patient care will not suffer. According to one such creditor attorney, "the staff in these industries are so dedicated. They will use their own energy and resources to protect patients if they have to."⁸⁰ Not surprisingly, attorneys for the elderly disagree; they think it is their clients who are taking the cuts on the chin.⁸¹ Either way, nursing homes and home-health care agencies in bankruptcy are now seeing a different kind of inefficiency, as funds are

⁷⁸ See Peterman, *supra* note 10, at 18. As Professor Prince noted during a discussion of this issue, while nursing homes were informed that there would be Medicaid cuts, they were not told specifically what would be cut and how the cuts would take place until just before they were implemented. As he further explained, "Published final rules with twelve-months of advanced notice would have permitted an orderly transition into [the] new comprehensive system." *Id.*

⁷⁹ See *id.* Of course, if it is true, as some bank lawyers claim, that these cases have affected only the debt structure and not the patients, then perhaps it doesn't matter how these industries were financed. These industries had become darlings of Wall Street; their stock prices had risen dramatically, based on industry profitability under the old reimbursement standards, as well as demographic data suggesting that this was a growing industry. See Peterman, *supra* note 10, at 6-9 (discussing the high stock values for the health care industry in the past, as well as the effect of the drop in revenues caused by the BBA).

⁸⁰ Interview between Nathalie Martin and Morton Branzberg, Partner, Klehr, Harrison, Harvey, Branzberg and Elhers, in Santa Fe, N.M. (May 20, 2000). Yet because of the booming economy and job market, it is harder than ever to keep these positions filled with qualified people. See Pear, *supra* note 8, at A1 (noting that "it [is] hard to attract and retain good workers in a booming economy, when the unemployment rate is at a 30-year low and other industries offer less demanding, better-paying jobs").

⁸¹ Telephone Interview between Nathalie Martin and Ellen Leitzer, Co-Director of the Senior Citizens Law Center in Albuquerque, New Mexico (May 3, 2001); see also *Nursing Home Bankruptcies*, *supra* note 7 (statement of Dr. Charles Roadman, II, President, American Health Care Association, discussing problems with access in rural areas and problems placing patients): *id.* (statement of John Ransom, Director, Healthcare Research, Raymond James Financial, stating that "the [nursing home] industry persists in a state of shock and demoralization, with extreme difficulty attracting labor and capital"); see also *Nursing Home Chain Files Chapter 11: Vencor Runs Six Local Centers*, DENVER POST, Sept. 14, 1999, at C14. The article states:

"Patients and their families should be concerned," said Sarah Green Berger, executive director of the National Citizens Coalition for Nursing Home Reform in Washington, D.C. "I would want to see the situation stabilized before I suggest anyone use a Vencor facility," Berger said. "You don't buy health care from a company that is not in sound financial condition because they won't give quality care."

See *id.*

directed away from patient care and into the hands of bankruptcy attorneys and accountants.

C. THE HIGH COSTS OF BANKRUPTCY

Legal and other professional fees can be extremely expensive in Chapter 11, making it difficult to operate profitably.⁸² Fees in a large Chapter 11 reorganization case often cost tens of millions of dollars, and for smaller firms, the fees sometimes equal the entire value of the firm.⁸³ Each month in bankruptcy adds to the debtor's financial obligations.⁸⁴

All Chapter 11 professional fees are paid out of a debtor's assets, either from profits or from a purchaser's investment money.⁸⁵ No business can reorganize if it cannot generate income over and above its current expenses.⁸⁶ It must either pay its debts with profits or become profitable enough to find a buyer to take over the business as a going concern. If a company cannot be sold as a going concern or cannot pay a

⁸² See 11 U.S.C. § 330 (1994 & Supp. V. 1999) (allowing the payment of professional fees in bankruptcy); see also LoPucki, *supra* note 74 at 50. LoPucki states that Chapter 11 "generates direct costs ranging from a low of about three percent of the entire value of the debtor's assets for large companies, to a high of over twenty-one percent for small companies." *Id.* citing:

Edward I. Altman, *A Further Empirical Investigation of the Bankruptcy Cost Question*, 39 J. FIN. 1067, 1076-78 (1984) (finding direct costs of large reorganization cases to average 6.0% of total assets); Daryl M. Guffey & William T. Moore, *Direct Bankruptcy Costs: Evidence from the Trucking Industry*, 26 FIN. REV. 223, 231 (1991); Robert M. Lawless et al., *A Glimpse at Professional Fees and Other Direct Costs in Small Firm Bankruptcies*, 1994 U. ILL. L. REV. 847, 868 (finding in a study of Chapter 11 cases in Memphis, Tennessee division of bankruptcy court, that direct costs of bankruptcy averaged 21.55% of debtors' total assets as reported in petition); Jerold B. Warner, *Bankruptcy Costs: Some Evidence*, 32 J. FIN. 337, 343 (1977) (finding direct costs of large reorganization cases to average 4.0% of market value of assets); Lawrence A. Weiss, *Bankruptcy Resolution: Direct Costs and Violation of Priority Claims*, 27 J. FIN. ECON. 285, 290 (1990) (finding direct costs in large reorganizations to average 3.1% of total assets); Michelle J. White, *Bankruptcy Costs and the New Bankruptcy Code*, 38 J. FIN. 477, 484 (1983) (finding direct costs of large reorganization cases to average 6.0% of disbursements to all creditors).

⁸³ See Douglas G. Baird & Randal C. Picker, *A Simple Noncooperative Bargaining Model of Corporate Reorganizations*, in CORPORATE BANKRUPTCY: ECONOMIC AND LEGAL PERSPECTIVES 168, 171 (Jagdeep S. Bhandari & Lawrence A. Weiss eds., 1996).

⁸⁴ See REORGANIZING FAILING BUSINESSES, *supra* note 62, at 12-6. In addition to the financial costs, the time spent in Chapter 11 can have an adverse impact on business and operations. See *id.* at 12-4 to 12-5. Thus, it is critical for a company in Chapter 11 to complete a reorganization plan, and quickly get out of bankruptcy.

⁸⁵ See 11 U.S.C. § 303.

⁸⁶ Under a common plan of reorganization, the debtor pays secured creditors in full over several years and pays past-due unsecured obligations, though not in full, over a similar time period. See *id.* § 1129. Obviously, these pre-petition obligations must be satisfied from funds over and above current operating expenses.

reorganization plan from profits, the company's assets will most likely be sold piece-meal, perhaps for an entirely different use.⁸⁷

Because post-bankruptcy attorneys' fees are paid before any other claims,⁸⁸ the best cost-cutting strategy available at the outset of any Chapter 11 case is to develop a business plan and an exit strategy for the bankruptcy case before it is filed. Pre-planning can greatly reduce the amount paid in legal and other professional fees,⁸⁹ and permit many debtors to reduce debt and become profitable. Unfortunately, it is difficult to plan in advance.

Chapter 11 adds other layers of expense to operations as well. If a debtor does not pay creditor claims in full, this is considered a "taking" of property under the Constitution.⁹⁰ Because it is unconstitutional to take property without due process of law, the debtor is required to provide some minimal due process to creditors,⁹¹ normally provided by giving written notice to creditors of the many of debtor's actions throughout the case. Paper notices circulate regarding every sale of assets outside the ordinary course of business, every employee bonus plan, and every contract rejection. Conversely, debtors must obtain court approval for virtually all business activity that it wishes to engage in that is outside the ordinary course of business. Of course, all of these additional procedures cost hours of attorney and staff time.⁹²

⁸⁷ See *id.* § 363(b) (allowing the sale of any "property of the estate"). While selling the assets as a "going concern" business is an obvious goal of Chapter 11, nothing in Section 363(b) limits sales to "going concern" sales. See Frederick Tung, *Taking Future Claims Serious: Future Claims and Successor Liability in Bankruptcy*, 49 CASE W. RES. L. REV. 435, 451. Even asset sales must be accomplished quickly if creditors are to be paid a meaningful distribution, because professional fees are paid before the claims of other creditors, including employee claims. See 11 U.S.C. §§ 503, 507. In order to keep nursing home residents in the same location, an obvious goal in most cases, the homes must remain operational. See Marilyn Denny, "This Is Who I Am, Don't Let Them Move Me," 2 QUINNIPIAC HEALTH L.J. 203, 203-04 (1999) (noting the trauma created when one moves a nursing home resident, even to a different room).

⁸⁸ See 11 U.S.C. § 507.

⁸⁹ See REORGANIZING FAILING BUSINESSES, *supra* note 62, at 12-6.

⁹⁰ See ALEXANDER GORDON, IV, GORDON ON MARYLAND FORECLOSURES 41-43. (1999 Supp.).

⁹¹ See COLLIER HANDBOOK, *supra* note 67, at 20-11.

⁹² See 11 U.S.C. § 363; COLLIER HANDBOOK, *supra* note 67, at 20-11 to 20-12; see also Deborah S. Griffin, *Post-Termination Bankruptcy Considerations for the Defaulted Contractor*, in 17 CONSTRUCTION LAW, 24, 32 (1997). A contractor-debtor filing a Chapter 11 petition, like any other debtor, faces a

variety of costs associated with a Chapter 11 reorganization effort, including the costs of having the [debtor's] attorneys address the legal aspects of the reorganization and the cost associated with redirecting company resources and personnel to pursue and resolve the administrative aspects of the case. In general, whenever bankruptcy court approval is necessary, there will be legal costs associated with the preparation and filing of motion papers, together with court appearances and the expense of negotiating and/or litigating disputes concerning the matters requiring court approval. Apart from the legal costs, the company will invariably need to

In addition, a debtor's staff is far, far busier in bankruptcy than outside of bankruptcy.⁹³ While in bankruptcy, the debtor's accounting staff will be required to prepare a variety of financial disclosures to many different constituents.⁹⁴ There are also the added employee costs of having people in court much of the time rather than at work.⁹⁵ For upper level management, bankruptcy can have high costs in employee morale,⁹⁶ product controls and quality, and even absenteeism. Also, employees may preemptively leave the company for fear of losing their jobs. Employees in accounts payable have the difficult job of explaining why the debtor cannot pay its pre-petition obligations outside a plan of reorganization.⁹⁷

devote some internal resources to prepare and assemble the data and other information necessary to seek such court approval most effectively. More specifically, [the debtor] will face expense in filing motions for the use of cash collateral, to assume or reject executory contracts, to respond to efforts seeking relief from the automatic stay, to review and to respond to proofs of claim submitted by creditors, to prepare and submit a disclosure statement, and to formulate, revise, negotiate and submit for approval a reorganization plan. In addition to the legal costs, company personnel and other resources will need to be utilized to gather the necessary information and to evaluate the company's continuing financial needs and the profitability of various [projects]. A debtor-in- possession also is required to file monthly operating statements with the U.S. Trustee or the court. The [debtor] faces additional expense in obtaining court approval for the engagement of professional persons (e.g., attorneys, accountants, appraisers) and for their periodic applications for compensation.

Id.

⁹³ See COLLIER HANDBOOK, *supra* note 67, at 24-13 (describing the tremendous additional burdens of a bankruptcy filing on the debtor's staff, including preparing extra disclosure documents, serving as witnesses at court hearings, keeping creditors happy despite pre-petition nonpayment, and trying to maintain or create employee morale); see also REORGANIZING FAILING BUSINESSES, *supra* note 62, at 1-7 (noting that, at the very time that the debtor's management is most needed to restructure the business, its time is taken up by huge numbers of administrative tasks associated with the bankruptcy proceeding).

⁹⁴ See Griffin, *supra* note 92, at 32 (noting the many disclosures required in Chapter 11, including disclosures to the United States Trustee, the secured lender, and the court, among others).

⁹⁵ See COLLIER HANDBOOK, *supra* note 67, at 24-13.

⁹⁶ See *id.*

⁹⁷ There are also other indirect costs created by a bankruptcy filing. The court approval process slows down business decisions, resulting in lost opportunity costs. See Reorganizing Failing Businesses, *supra* note 62, at 1-8. Debtors in bankruptcy also must pay new deposits for utilities. See 11 U.S.C. § 366 (1994 & Supp. V. 1999). Many suppliers will also demand cash-on-delivery after bankruptcy, causing cash flow problems. Wealthier debtors can obtain larger credit lines from their banks to make up for this increased demand for cash, but banks may ask for a higher interest rate, further reducing profits and the likelihood of survival. Smaller debtors could have difficulty obtaining credit at any rate, and thus might have to do without some supplies or reduce other expenses. Some companies will simply go out of business on a moment's notice. This has happened in the nursing home industry, leaving residents in one California home scrambling to find replacement services on less than 24 hours' notice. See Garmen Shiu, Nursing Home Residents Left Homeless: Bankruptcy Shuts Down Reseda Care Center Without Warning, at <http://www.cbs2.com/news/stories/news-970927-013926.html> (Sept. 27, 1997).

Long-term care firms that are in bankruptcy must pay all these additional administrative costs, as well as regular operating costs, on a reduced budget.⁹⁸ Moreover, most bankruptcy debtors are expected to reduce costs even further once they file for bankruptcy, as a showing of good faith in trying to reorganize.⁹⁹ Yet few expenses *can* be reduced without affecting patient and resident care. Staff is an obvious place to cut costs because it is one of the biggest overhead items.¹⁰⁰ Reducing staff does, however, dramatically affect care.¹⁰¹ Since the BBA, homes have drastically cut back on staff; as a result, residents have been injured more and had more bedsores, not to mention other health problems.¹⁰² Although large lenders have more leverage than most smaller creditors, bank debt probably cannot be reduced significantly until other essentials like supplies and utilities are cut first.¹⁰³

While not all of the long-term care providers that are in bankruptcy will go out of business, the additional costs of Chapter 11 will make it more difficult for these firms to survive.¹⁰⁴ These bankruptcies, caused

⁹⁸ See *supra* Part II.A.

⁹⁹ See COLLIER HANDBOOK, *supra* note 67, at 24-21 (listing common means of cutting costs, such as reducing insurance, reducing staff, cutting utility usage, selling off unprofitable assets or divisions, cutting out company cars and other expense items, leasing out extra space, and rejecting unprofitable contracts).

¹⁰⁰ See *id.*

¹⁰¹ See Pear, *supra* note 8, at A1.

¹⁰² See *id.* In fact, the harm to patients due to reduced staff has reportedly been so grave that Congress is now considering legislation that would set federal guidelines for how many staff hours each patient must receive. See *id.* Homes will be unable to afford to hire the required people due to the prior legislative acts of Congress, however, which caused the very problem about which Congress now complains. Notably, passing such a law under current economic conditions would not increase staffing in nursing homes and would in no way change the care being received by nursing home residents.

¹⁰³ See COLLIER HANDBOOK, *supra* note 67, at 25A-8 (discussing the need to abide by a strict budget if a debtor must borrow money from a lender post-petition). Secured creditors have greater leverage in a Chapter 11 case than unsecured creditors, and can thus demand cost reductions at the expense of other creditors. See Ronald J. Mann, *Bankruptcy and the Entitlements of the Government: Whose Money Is It, Anyway?*, 70 N.Y.U. L. REV. 993, 1058 (1995) (noting that bankruptcy gives secured creditors the power to destroy an unsecured creditors leverage with one stroke).

¹⁰⁴ See James E. Bowers, *Rehabilitation, Redistribution, or Dissipation: The Evidence for Choosing Between Bankruptcy Hypotheses*, 72 WASH. U. L. Q. 955, 962 (1994) (noting that the evidence does not suggest that Chapter 11 is effective in most cases); Edith S. Hotchkiss, *The Post-Bankruptcy Performance of Firms Emerging from Chapter 11*, 50 J. FIN. 3,4 (1995) (finding that 40% of firms emerging from bankruptcy continued in financial distress, with over 32% filing Chapter 11 again); Lynn M. LoPucki & William C. Whitford, *Patterns in the Bankruptcy Reorganization of Large, Publicly-Held Companies*, 78 CORNELL L. REV. 598, 601 n.13 (1993) (noting that "it is estimated that no more than 30% will result in confirmed reorganization plans"). Ultimately, only about 10% of all reorganizing debtors actually succeed at reorganizing. See Elizabeth Warren, *Bankruptcy Policymaking in an Imperfect World*, 92 MICH. L. REV. 336, 373 n.99 (1993).

almost exclusively by an uninformed act of Congress,¹⁰⁵ have created unnecessary inefficiency and pain, all of which could have been avoided through better preparation and research. These cases have cost millions of dollars,¹⁰⁶ which could have been used either to care for patients or to reduce bank debt in these industries. The money could also have been used to pay down financial obligations, thus aiding patients by minimizing their chances of receiving substandard care, as well as the likelihood of displacement.

D. SQUARE PEGS IN ROUND HOLES: RESIDENTS HOLD NON-ECONOMIC INTERESTS IN THEIR FACILITIES' BANKRUPTCIES

Residents risk more in bankruptcy than merely undermined care created by cash flow problems. The Bankruptcy Court's primary job in any federal bankruptcy case is to ensure payment to creditors, rather than to further resident and patient interests.¹⁰⁷ Traditionally, residents of health-care facilities had absolutely no standing to be heard in the bankruptcy case of their facility and thus no rights in the case at all.¹⁰⁸ While courts are now permitted to balance the interests of health-care recipients in a health care bankruptcy due to an amendment to the Bankruptcy Code,¹⁰⁹ judges are not used to engaging in this type of balancing. Most are accustomed to weighing economic interests only.¹¹⁰ It is unclear how these non-economic interests will be balanced against competing economic claims, assuming judges are willing to consider them at all.¹¹¹

¹⁰⁵ See Fischer, *supra* note 4, at P01A (stating that at least one Congressperson believes Congress did not know the effects of the BBA when it enacted the legislation).

¹⁰⁶ Author Nathalie Martin and research assistants Marisol Cintron Garcia, Sean Garrett, and Daniela Gonzales, have gathered extensive data regarding the professional fees that have been requested and allowed in these five large nursing home chain bankruptcies. Not all data was available to us. Thus, the actual fees requested and allowed in these cases could be far higher than those reported here. As of October 10, 2000, over \$44 million in professional fees had been requested and over \$33 million in professional fees had been allowed and presumably paid by the debtors in these cases. Based upon the orders approving professional fees entered in these cases thus far, it appears very likely that the remaining \$11 million in fees requested as of October 10, 2000 will be allowed as requested. Additionally, these cases are nowhere near completion. None of these debtors have proposed, let alone confirmed, a Chapter 11 plan, suggesting that millions of additional professional fees will be paid in these cases before they are resolved. All data supporting this footnote is on file with author, Nathalie Martin.

¹⁰⁷ See Lawrence P. Schnapf, *CERCLA and the Substantial Continuity Test: A Unifying Proposal for Imposing CERCLA Liability Asset on Purchasers*, 4 ENVTL. LAW 435, 507 (1998) (stating that the purpose of Chapter 11 is to "restructure a business so that it may operate, employ workers, pay its creditors, and produce a return for shareholders).

¹⁰⁸ See Nathalie Martin, *Noneconomic Interest in Bankruptcy: Standing on the Outside Looking In*, 59 OHIO STATE L.J. 429, 446-52 (1998).

¹⁰⁹ See Bankruptcy Reform Act of 1999, H.R. 833, 106th Cong. § 1104 (1999).

¹¹⁰ See Martin, *supra* note 108, at 446-52.

¹¹¹ See Peterman, *supra* note 10, at 20-24, which contains a lively conversation about the difficulty of balancing economic and non-economic interests. See generally Martin, *supra*

Thus, it is unclear what practical ramifications these bankruptcies will have on residents and patients.

E. THE EFFECT OF THE BANKRUPTCY CODE ON STATE STATUTES
REGULATING PATIENT CARE

Theoretically, the mere fact that a bankruptcy has been filed should not reduce the quality of care that residents and patients receive. State health guideline regulations should continue to be enforced. The Bankruptcy Code, however, under the Supremacy Clause of the U.S. Constitution, overrides some state laws.¹¹² Thus, the automatic stay imposed upon bankruptcy may give homes and providers some flexibility in meeting state regulatory guidelines.¹¹³ For example, in the past, bankruptcy courts have refused to uphold licensing and certification statutes for nursing homes and hospitals because the statutory standard for obtaining a license was based upon financial condition, or because enforcing the statute would have a detrimental effect on the debtor's reorganization efforts.¹¹⁴ In light of these precedents, courts might also refuse to enforce statutes that regulate minimum levels of staffing, assuming that the debtor could not afford to hire enough staff persons.¹¹⁵ While some state regulations will continue to be enforced in bankruptcy, there is no reason to believe that *all* such regulations will be enforced, particularly if they make it difficult for the debtor to reorganize.

Thus, for a number of reasons, nursing home and home-health care bankruptcies could have a very negative impact on the recipients of such care.¹¹⁶ First, the large costs of Chapter 11 could make it difficult for homes and agencies to operate at a profit. Second, a nursing home could stay operational but offer compromised care as a result of its financial condition. Third, the state statutes that purport to protect residents and patients might not be enforced if enforcement would interfere with the debtor's reorganization efforts. Finally, whether and how a bankruptcy

note 108 (in which one of the authors of this article dedicates 70 pages to this issue). Of course, it is always possible that a bankruptcy court could impose even tougher standards on patient care than a state would. Recently, in an unprecedented move, the Bankruptcy Court in the Vencor case approved an arrangement under which the federal government will oversee Vencor's patient care quality while it completes its reorganization effort. See Chris Adams, *Vencor to Give U.S. the Power to Oversee Care*, WALL ST. J., Aug. 9, 2000, at B2.

¹¹² See U.S. CONST., art. VI, cl. 2; MARTIN J. BIENENSTOCK, *BANKRUPTCY REORGANIZATION* 90 (1987).

¹¹³ See 11 U.S.C. § 362 (1994 & Supp. V. 1999) ; Nathalie Martin, *The Insolvent Life-Care Provider: Who Leads the Dance Between the Federal Code and State Continuing Care Statutes?* 61 OHIO STATE L.J. 267, 296 n.164. In this article, one of the authors discusses various ways in which bankruptcy courts can avoid enforcing state statutes that make it more difficult for a debtor-corporation to reorganize. See *id.*

¹¹⁴ See Martin, *supra* note 113, at 296.

¹¹⁵ See Pear, *supra* note 8, at A1.

¹¹⁶ See *supra* Part III.

court would attempt to protect the non-economic interests of residents and patients is entirely unknown. None of these potential harms are inevitable; all could have been avoided and can still be avoided in the future.

III. LIMITATIONS ON AVAILABLE CARE SINCE THE BBA

The fact that many homes and providers are in bankruptcy is not a primary cause for concern. These bankruptcies are merely a symptom of industry-wide financial problems. What is a primary cause for concern, however, is that some people can no longer gain access to nursing care, as a direct result of the reimbursement cuts. The reason for this is that the new reimbursement scheme induces providers to refuse care to the sickest patients.

While insisting that care standards will not change as a result of the changed reimbursement policies, the December 1999 GAO report admits that the new reimbursement policies have made it harder for some patients to gain admission to nursing homes.¹¹⁷ According to the report, nursing homes are being far more selective in accepting patients since the enactment of the BBA.¹¹⁸ Nursing homes are now turning away sicker patients because caring for these patients could cause the provider to lose money.¹¹⁹ Healthy patients, on the other hand, are seen as assets that could help a home return to solvency. The admissions process has become so competitive in some places that homes are requesting extensive medical records and drug charts before granting admission.¹²⁰ Some homes are even going to hospitals to interview patients and assess their condition before granting them admission.¹²¹ This change constitutes more than a minor inconvenience. This denial of access creates a perverse form of "health care" in which the healthy are welcome but the sick are turned away.

Access problems are even more pronounced in the home-health care industry.¹²² The GAO report relating to home-health care insists that the cuts simply put the weaker agencies out of business, that the cuts only

¹¹⁷ See DEC. 1999 GAO REPORT, *supra* note 7 at 2.

¹¹⁸ See *id.*

¹¹⁹ See Fischer, *supra* note 4, at P01A (quoting one nursing home administrator as saying that he would hesitate to take someone with 24-hour ventilator needs because his facility would be unable to provide that care under the current reimbursement system). While homes and home-health care providers sometimes get more money for sicker patients under the new system, they do not get enough more money to cover the higher costs of caring for these people. Thus, the financial incentives do not encourage providers to treat or accept sicker patients; those most in need find it hardest to obtain treatment and care.

¹²⁰ See Adams, *supra* note 39, at A20.

¹²¹ See *id.*

¹²² See Adams, *supra* note 35 (stating that as many as fifty percent of home health agencies have gone out of business since the Medicare cuts).

affected agencies that were abusing the system and providing unnecessary care, and that there are still plenty of providers available to provide care.¹²³ In reality, the cuts punished the providers that were efficient, by making across the board percentage cuts that could only be endured by previously inefficient providers.¹²⁴

In light of the fact that people are being denied access to publicly funded nursing homes and home-health care for financial reason, the GAO's many statements that care is not being affected by the cuts are empty. Even if it were true that people who were actually receiving care were still receiving the same *quality* of care, the care has changed markedly for people who cannot gain access to long-term care. The available care for these individuals has gone from at least tolerable to non-existent. Although the GAO reports that patients are still getting the care they need, it is not true. When the sickest elderly people in America cannot gain access to a nursing home, or to comparable home-health care, these industries have failed. We do not need thousands of bankruptcies to establish that.

IV. ESTABLISHING OUR NATIONAL POLICY TOWARD FUNDING LONG-TERM CARE: UNEARTHING THE TABOOS

Congress had reason to be concerned about fraud and profligate spending among long-term care providers. According to many sources, including authors of scholarly articles, the system of reimbursing unlimited rehabilitation services created the wrong incentives.¹²⁵ Nevertheless, it seems unlikely that Congress recognized the full economic impact that the BBA would have on these industries.¹²⁶ Put another way, it seems unlikely that the purpose behind the BBA was to bankrupt the nursing home and the home-health care industries.¹²⁷ While this may not

¹²³ See generally MAY 1999 GAO REPORT, *supra* note 7. This report acknowledges that the revenue cuts were hardest on agencies that "provided more visits per user, for smaller agencies, and for those less able to recruit low-cost patients." *Id.* at 3. The same report states that "the beneficiaries who are likely to be costlier than average to treat may have increased difficulty in obtaining health care." *Id.* at 24.

¹²⁴ See Kelly, *supra* note 4, at A1. In other words, only agencies that had fat to cut could endure the cuts. Thus, many of the most efficient providers, as well as those providing services to the poor, are now out of business. See *id.*

¹²⁵ Home-health care was the fastest growing part of the Medicare budget, and increased its budget from 2.6 billion to 17.2 billion between 1989 and 1997. See COMM. ON GOV'T REFORM & OVERSIGHT, *supra* note 11, at 4. False claims were also common. See *id.* at 5. Thus, this industry was an easy target for cuts.

¹²⁶ See Fischer, *supra* note 4, at P01A.

¹²⁷ See COMM. ON GOV'T REFORM & OVERSIGHT, *supra* note 11 at 4 ("To address the continuing problems of waste, fraud, and abuse in the home health program, the Congress proposed several changes to the home health program, contained in the Balanced Budget Act of 1997.").

have been a result that Congress intended, it was certainly foreseeable that the cuts in Medicare mandated by the BBA, would have an adverse effect on health care programs that served the elderly, and thus on the health of the elderly themselves. However, Congress was quite willing to take this risk.

Congress' goals in cutting Medicare spending appear either overly simplistic or, more cynically, elusive and convoluted. One goal may have been to eliminate some of the less profitable facilities or to eliminate those that were no longer considered necessary. Some economists and analysts claim that traditional nursing home care is less in demand now that continuing-care contracts, assisted living facilities, and home-health care are available.¹²⁸ Yet for most people, these other options can only be accessed through private funds.¹²⁹ Since most people cannot afford to fully fund their own long-term care, the usual method of paying for long-term care is to expend one's own assets first, and then go on Medicaid¹³⁰ after exhausting private funds.¹³¹ For most people, Medicaid funds nursing home care, but not the other options for care.¹³² Thus, most of these options are temporary and do not eliminate the need for many people to move to a nursing home at a later time.¹³³ Demographic studies show that as the number of aging people increases, more care will be needed for chronic health problems.¹³⁴ The population is

¹²⁸ See *Analysts: Nursing Home Companies Face Many Difficulties*, FED. FILING NEWSWIREs, Jan. 18, 2000.

¹²⁹ See Nathalie Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risk Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL. 335, 356-66 (2000).

¹³⁰ Medicare is a federal health insurance program for the elderly (age 65 or older) and for certain disabled persons. Eligibility and benefits are the same throughout the country. Medicaid is a public health care program that serves low-income people. It is funded by both State and federal funds. Medicaid programs are administered by the individual states, and each state's Medicaid program has different eligibility rules and benefits. See National Asian Pacific Center on Aging, *Medicare v. Medicaid*, at <http://www.napca.org/mvsm.html> (last visited April 8, 2001).

¹³¹ See Schifano & Zucarelli, *supra* note 57, at 9A.

¹³² See *id.*

¹³³ See Martin, *supra* note 129, at 356-59, 360-66. People can only live in assisted living for as long as they can care for themselves, so many people move to a nursing home after living in assisted living. See *id.* at 360-61. All of the options to traditional nursing homes are so expensive that the average person will expend their funds on home-health care or assisted living before they die, requiring a later move to a Medicaid-funded nursing home. See *id.* at 365-66.

¹³⁴ See Analysts, *supra* note 128. Because nursing homes tend to be depressing places that most people want to avoid, and because initial studies show that some care can be provided more economically at home, we had hoped that American long-term care was moving away from nursing care and toward a home-health care model. In fact, a recent Supreme Court case, *Olmstead v. L.C.*, 527 U.S. 581 (1999), mandates that care be provided in the least obtrusive way possible. Because home health care is less intrusive than care provided in group homes this case suggests that states may be required to provide more home care in lieu of nursing-home care. Now, however, this does not seem to be possible. The home-health care industry has shrunk rather than grown, and is serving a far smaller portion of the population.

aging and birth rates are down.¹³⁵ While there are plenty of Americans working today, thus funding both Social Security and national long-term care costs, as the baby boomers age, there will be fewer Americans working, resulting in fewer tax dollars available to fund the nation's long-term care costs. Thus, there is no reason to think that we have more nursing homes than we need. Moreover, given our future needs, we should be increasing rather than decreasing funding for long-term care, as well as investing some public funds for future long-term care costs. Consequently, if Congress' goal were to eliminate "unnecessary" facilities, Congress was, at best, acting in a shortsightedly and without full information. At worst, Congress was aware of the impact that the BBA would have on elderly people who would eventually need nursing home care, but did not consider this to be a serious concern.

As a society, we have not yet established our goals or priorities with respect to long-term care, and certainly have not engaged in a public discourse about which long-term care services we actually want to pay for with public funds.¹³⁶ Moreover, we have not decided which services really are necessary versus those that are unnecessary.¹³⁷ We have not established guidelines for what quality of care is required to be provided or even examined whether Americans have a right to long-term care paid for through Medicare.¹³⁸ If we are going to change the amount of federal

Thus, it is impractical at this point to move toward home-health care and away from nursing home care. If this is our goal as a society, we must find ways to tighten the controls on fraudulent claims and unnecessary services, without eliminating so much badly needed care.

¹³⁵ Erick J. Bohlman, *Financing Strategies: Long-Term Care for the Elderly*, 2 ELDER L.J. 167, 167 n.4 (1994). According to Bohlman, in 1900, 4% of the population was age sixty-five or older. *Id.* By 1977, 10.8% of the population was sixty-five or older. *Id.* By 1980, that figure had increased to 11%. *Id.* Projections are that by 2010, 12.7% of the population will be at least sixty-five, and that by 2030, 18.3% of the population will have reached that age. *Id.* Within only fifty years, nearly one out of every five living Americans will be "elderly" by our current standards. *Id.* Furthermore, the "elderly" as a group are getting older: the percentage of elderly individuals at least seventy-five years of age will rise from 37.7% of the total elderly population as of 1977 to 42.1% by 2030. *Id.*

¹³⁶ Several studies show that prior to the BBA, providers rendered services that were not necessary in order to increase profits. See COMM. ON GOV'T REFORM & OVERSIGHT, *supra* note 11 at 5-11.

¹³⁷ What about therapies that have been proven to expand the human life span? An even more difficult question is whether we want to extend the human life span? Do we want to expand the human life span in all cases, or only if the person has her own funds and can lead a relatively healthy and meaningful life, whatever that means? Finally, do we want as a society to pay for the care a person receives toward the end of a long life?

¹³⁸ It appears that there is no Constitutional right to health care or welfare benefits. See, e.g., Scott D. Littman, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871, 877 (1998)(healthcare); April Land, *Children in Poverty: In Search of State and Federal Protections for Children in the Wake of Welfare Reform*, __ UTAH L. REV. __ (2000) (forthcoming)(welfare). Perhaps it follows that there is no right to long-term care paid for through Medicare. However, Medicare has paid for such care, for both the poor and the middle class, for over four decades.

funds directed at this care, or its quality or availability, we should make the decision to do so consciously. Yet Congress did not do this when it promulgated the BBA.

Some people openly wish to change the level of support for long-term care to make it less expensive and less available. One congressman flatly stated, when asked about the effects of the cuts, that Medicare was never meant to be a welfare program.¹³⁹ Proponents of the “intergenerational equity movement” believe that we are spending too much of our federal and state budgets on the elderly.¹⁴⁰ According to proponents of this view, the elderly are receiving a disproportionately large share of the available federal funding, so that “a generation of young Americans will eventually live in financial slavery, amidst a deteriorating environment and crumbling infrastructures”¹⁴¹ Other proponents of intergenerational equity claim that the current system is tantamount to fiscal child abuse.¹⁴²

These may sound like fringe rather than mainstream ideas, but they may be more common than we realize. In a speech to Congress on February 8, 2000, David Walker, Comptroller General of the United States, expressed intergenerational ideas when he cautioned Congress to be careful in reversing cuts mandated by the BBA.¹⁴³ He noted that after thirty years of deficits, a “combination of hard choices and remarkable economic growth has created a budget surplus.”¹⁴⁴ He asked that before reversing the BBA, Congress do a careful assessment of the effects the reversals will have.¹⁴⁵ While admitting that the financial ramifications of the BBA “can be far off the mark,”¹⁴⁶ he nevertheless asked Congress to separate the trivial from the important and to resist demands of special interest groups.¹⁴⁷

¹³⁹ See CONGRESS DAILY A.M., July 26, 2000, available at 2000 WL 24187230 (Fortney (Pete) Stark, D-Calif., stated, “Medicare was a program set up in 1965 to help the nation’s seniors and disabled It is not a provider [sic] welfare program.”).

¹⁴⁰ Hans Riemer & Christopher Cuomo, *The Generation Gambit: The Right’s Imaginary Rift Between the Young and the Old*, at <http://www.fair.org/extra/9703/generation.html> (Mar./Apr. 1997).

¹⁴¹ Richard Chin, *Public Benefits Debate Becomes War of the Ages: How to Divide Resources Fairly is a Heated Issue*, PIONEER PRESS, <http://www.pioneerplanet.com/archive/gen/dox/gen14.htm> (Nov. 17, 1996).

¹⁴² See *id.*

¹⁴³ See *Medicare: Program Reform and Modernization Are Needed But Entail Considerable Challenges: Hearing Before the Senate the Special Comm. on Aging*, 106th Cong. 1 (2000) (statement of David M. Walker, Comptroller General of the United States).

¹⁴⁴ *Id.* at 1.

¹⁴⁵ See *id.* at 4.

¹⁴⁶ *Id.* at 22.

¹⁴⁷ See *id.* at 23 (“Steadfastness is needed when particular interest pit the primacy of their needs against the more global interests of making Medicare affordable, sustainable, and effective for current and future generations of Americans.”).

He noted that we must be careful to use the surplus to improve prospects for future generations.¹⁴⁸ He referred to the present generation as the stewards for future generations,¹⁴⁹ and asked Congress to recognize that health care costs necessarily “compete with other legitimate priorities in the budget.”¹⁵⁰ He claimed that the projected growth of health care costs “threatens to crowd out future generations’ flexibility to decide which of these competing priorities will be met.”¹⁵¹ He stated that today’s generation has a responsibility toward future generations to reduce the debt burden they will inherit and to provide a strong foundation for future income growth.¹⁵² Perhaps he was willing to state directly what Congress would not: that in order to save money for other priorities, the federal government must be willing to sacrifice some of the elderly’s needs. This level of bluntness is not likely to win votes for members of Congress, which may be why Congress will not be honest about what is happening, but unelected officials will.

Our health plan is known as one of the most expensive and inequitable health-care system in the world,¹⁵³ and a huge percentage of our health care resources are spent on long-term care.¹⁵⁴ Does this make young people angry or resentful?¹⁵⁵ Was concern over intergenerational equity in the back of the minds of Congress when they passed the Balanced Budget Act? Common sense suggests that the answer is no.¹⁵⁶ Rather than being motivated by intergenerational equity, Congress did not appear to know or understand exactly what it was doing.¹⁵⁷ But it

¹⁴⁸ See *id.*

¹⁴⁹ See *id.*

¹⁵⁰ *Id.* at 3.

¹⁵¹ See *id.* at 3.

¹⁵² See *id.* at 22.

¹⁵³ See Candace Johnson Redden, *Rationing Care in the Community: Engaging Citizens in Health Care Decision Making*, 24 J. HEALTH POL. POL’Y & L. 1363, 1366 (1999).

¹⁵⁴ See Nina J. Crimm, *Tax Plan for the Twenty-First Century: Medical Incentive Vouchers Address the Needs of Academic Health Centers and the Elderly*, 71 TUL. L. REV. 653, 667-68 (1997). This author notes that health care expenditures for the elderly greatly exceed those of the population in general and that health care for the elderly accounts for a disproportionate share of the nation’s health care costs. See *id.* at 667; see also Edward P. Richards, *Past as Prologue: Can Managed Care Overcome the Conflicts Inherited from Fee-for-Service Medicine*, 66 UMKC L. REV. 735, 740 (1998). As people live longer the absolute number of person needing health care increases. Thereafter, lifesaving measures that were not available 50 years ago add to these numbers. See *id.* at 741. Moreover, older people generally require more care than younger people, and at the same time, these people are frequently not working and therefore not contributing to the Gross National Product. See *id.* at 740. Necessarily, these demographic trends drive up the overall costs of health care in this country. See *id.*

¹⁵⁵ We of course assume that older people want to keep whatever services we currently have for the elderly, because they may need the services themselves.

¹⁵⁶ Most of the members of Congress are older, or at least have parents that could need long-term care. One would expect Congress to act in both self-interest and national interest.

¹⁵⁷ See Fischer, *supra* note 4, at P01A. Senator Jay Rockefeller of West Virginia has acknowledged that Congress enacted the BBA without having any idea of its real effects. See

should know what it is doing. At least someone should know what we as a nation are doing about long-term care; what we are doing to see that it is adequate today and what we are doing to see that it will be adequate twenty years from now. We need a separate, more informed process and forum for establishing our national priorities with respect to funding long-term care. This complex discussion cannot take place on the House and Senate floors, amidst discussions of numerous other issues. Congress needs far more direction from policy makers about how budget cuts will affect the public, and should not be permitted to make cuts without such direction.

Moreover, it is unlikely that Congress can discuss this taboo issue without losing voter support. Consequently, the conversation about public funding for long-term care must occur elsewhere, perhaps through a task force, a study by professionals within these industries, a national referendum, or another less political forum. One way or another, we as a society must decide how issues regarding the payment for long-term care will be made, and this must be done sooner rather than later.

We also must address the inevitable issue of health-care rationing. Virtually every country with a comprehensive health-care plan has overt guidelines for rationing health care.¹⁵⁸ The goal of rationing plans is to ensure that everyone receives some level of health care - that one group in society does not hoard it. Some scholars believe that rationing should be avoided because they worry about fair allocation of health care services or fear that they themselves may be denied needed care.¹⁵⁹ Rationing, however, cannot be avoided when funds are limited. Whether a country or state implements an overt rationing scheme or not, rationing happens. In places without overt rationing schemes, rationing decisions

id. In his own words, "we made a mistake." *Id.* Another congressman from West Virginia seemed aware of the effects the legislation would have. *See id.* Representative Nick Joe Rahall, who voted against the cuts, states, "It was destined to cause problems and it did and it does." *Id.* He thought all along "balancing the budget on the backs of seniors was a bad idea." *Id.*

¹⁵⁸ *See* Eric Lammond Robinson, Note, *The Oregon Health Services Act: A Model for State Reform?*, 45 VAND. L. REV. 977, 985-6 (1992). As this author explains, the United States must eventually face the fact that rationing is a necessity, because like all other countries in the world, our health care system cannot possibly serve all legitimate needs; it's just not financially possible. Even countries with universal health care ration care as a financial necessity. *See also* Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 9, 128 (1999) (noting that despite philosophical resistance to it, the United States does ration health care, as do all other countries in the world); Michael J. Malinowski, *Globalization of Biotechnology and the Public Health Challenges Accompanying It*, 60 ALB. L. REV. 119, 148, (1996) (noting that rationing is relatively well accepted in Britain, where it has taken place openly, under nationalized medicine). There are drastic differences in the number of patients who receive surgery, or even chemotherapy for cancer, however, when health care is rationed. *See id.* at 169 n.148.

¹⁵⁹ *See* Robinson, *supra* note 158, at 984.

are made by individual health care providers, based on the circumstances of the case.¹⁶⁰ These informal bedside rationing policies force healthcare providers to make the tough decisions while the rest of society pretends that rationing does not exist.

The BBA rationed health care for the elderly. Rather than implementing such a scheme unknowingly or behind closed doors, it would be preferable to have a public discourse about rationing long-term care. That, however, also requires a public discourse about death, something we seem willing to avoid at all costs. Americans have an unusually unhealthy attitude toward death and old age, which may lead to our ambivalence and indecision about long-term care.¹⁶¹

As one of two industrialized societies in the world with *no* comprehensive national health care plan,¹⁶² and as a country with no national policy toward aging, we need a policy as well as an implementation plan. Otherwise, we will pass omnibus bills that have not been fully researched and that Congress does not understand. We cannot rely on Congress to decide what our national policy with respect to long-term care will be. Rather, we need to decide what our goals are and then ask Congress to implement those goals.

¹⁶⁰ See Richard D. Lam, *Rationing Health Care: Inevitable and Desirable*, 140 PA. L. REV. 1511, 1519-20 (1992).

¹⁶¹ We find this attitude and general fear of death odd, in light of the fact that the majority of Americans believe in some form of life after death. See OPINIONS '90: EXTRACTS FROM PUBLIC OPINION SURVEYS AND POLLS CONDUCTED BY BUSINESS, GOVERNMENT, PROFESSIONAL AND NEWS ORGANIZATIONS 469 (Chris John Miko & Edward Weiland eds., 1991) (indicating that 70-80% of Americans believe in eternal life); *id.* at 477 (indicating that in 1988, 90% of the people polled in Ohio believed in eternal life). Authors have long written about this prevailing belief in life after death. See JOSEPH HEAD & S. L. CRANSTON, REINCARNATION IN WORLD THOUGHT 132-33 (1967). Quoting philosopher Paul Tillich, these authors describe heaven as

a bodiless continuation of the experiences and activities of this life. The classical doctrine of immortality has become a popular Christian [belief.] . . . One continues to live after one has died in almost the same way, but without a body - blessed spirits, walking on beautiful meadows.

Id. Given this imagery, it is hard to imagine why anyone would not *want* to die. Philosophers and psychologists have long noted that this is not the case, however. See JONATHAN DOLLIMORE, DEATH, DESIRE AND LOSS IN WESTERN CULTURE 119 (1998). As Freud noted in 1915, in an essay entitled *Our Attitude Toward Death*, "[w]e show an unmistakable tendency to put death to one side, to eliminate it from life. We [try] to hush it up." *Id.* In Bali, by contrast, death is celebrated as the dead person is moved up the chain of reincarnation, or directly to heaven, through soul purification. See ANGELA HOBART, URS RAMSEYER & ALBERYT LEEMAN, THE PEOPLES OF BALI 123-26 (1996). The cremations of Bali are not somber affairs, but rather happy occasions. See J. STEPHEN LANSING, THE BALINESE 31-33 (1995). Even in Mexico, the gods of death are revered and respected in the annual celebration of the day of the dead. See JUANITA GARCIGODOY, DIGGING THE DAYS OF THE DEAD: A READING OF MEXICO'S DIAS DE MUERTOS 2-3 (1998); ELIZABETH CARMICHAEL & CHLOE SAYER, THE SKELETON AT THE FEAST: THE DAY OF THE DEAD IN MEXICO 14-15 (1992).

¹⁶² See Robinson, *supra* note 158, at 980.