KEEPING UP WITH THE TIMES: A PROPOSED CHANGE TO MEDICARE AND MEDICAID NON-ASSIGNMENT CLAUSES FOR SECURED FINANCING

Comment

Cameron Brumfield *

I. INTRODUCTION ................................................................. 110
   A. A Common Occurrence for Healthcare Providers ............... 111
   B. Roadmap .................................................................. 113

II. SECURITY INTERESTS AND HEALTHCARE INSURANCE RECEIVABLES .......................................................... 114
   A. Secured Financing Provides Lower Interest Rates in Commercial Lending .................................................. 114
   B. Healthcare Insurance Receivables as a Secured Interest .... 115
   C. Gaining Security Interests in Government Entitlement Programs Such as Medicaid .................................. 117
   D. The Patient Protection and Affordable Care Act .............. 119

III. ADDING PPACA HEALTHCARE INSURANCE PLANS INTO THE MIX OF CURRENT TREATMENT ................................................ 120
   A. Benefits of the Effects of the PPACA to Healthcare Providers ....................................................................... 120
   B. Effect of PPACA on Commercial Lenders .......................... 122

IV. PROPOSED CHANGE TO NON-ASSIGNMENT STATUTES ........ 124
   A. Reasoning Behind Non-Assignment Statutes ................. 124
   B. Change to the Non-Assignment Statutes ......................... 125
      1. Creating an Exception to the Non-Assignment Statutes... 125
      2. Eliminating the Anti-Assignment Statutes Altogether ...... 127
      3. Outlawing or Regulating Double Lockbox Systems ....... 128
   C. Problems Arising from an Exception to the Non-Assignment Clauses ......................................................... 129

V. CONCLUSION .................................................................. 131

* Candidate for Juris Doctor, May 2015, Texas Tech University School of Law; B.B.A. in Marketing and Management, 2012, Texas Tech University. A native of Breckenridge, Texas, Mr. Brumfield is seeking a concentration in Health Law and served as the Student Bar Association President in 2014. He attributes the successful publication of this Comment to Professor Sally Henry who gave him the idea for the topic, editors Katie Olsen and Alex Good for their help and advice along the way, and finally to the Business & Bankruptcy Law Journal’s staff editors for Volume 2.
I. INTRODUCTION

“The [individual mandate of the Patient Protection and Affordable Care Act], together with other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, healthcare services . . . .”

While this may be true, initially only the demand for healthcare will increase. Prior to the enactment of the Patient Protection and Affordable Care Act (the Act), there were approximately forty-eight million uninsured Americans. Healthcare will become more affordable to all of those who obtain insurance that did not have any before. Because healthcare is more affordable, those individuals will likely have more doctor or hospital visits, have procedures they previously could not afford, and have more diagnostic tests run on them such as MRIs, CT scans, and X-ray scans. This is the increase in demand for healthcare services. But how will the individual mandate of the Act increase the supply of healthcare services?

To meet the increased demand for healthcare services, hospitals, clinics, and other medical offices will need to increase their staff, medical professionals, and equipment. The increases in staff, medical professionals, and equipment will generate new expenses for healthcare providers. The increase in demand may also lead to the creation of new healthcare providers.

4. Christensen, supra note 2 (“When the mandatory insurance rules of Obamacare kick in next year . . . you can bet more people are going to want to use their health benefits.”).
5. See id. (noting the current shortage in healthcare professionals and explaining that, in order to meet the coming demand, there will need to be an increase in providers). But see Marc Siegel, Will Your Doctor Quit? Obamacare Foretells Mass Exodus from Patient Care, FORBES (Aug. 12, 2012), http://www.forbes.com/sites/marc siegel/2012/08/12/will-your-doctor-quit-obamacare-foretells-mass-exodus-from-patient-care/ (stating 83% of physicians have considered leaving the practice of medicine).
6. Bruce Japsen, As Obamacare Rolls Out, Retail Clinics are Booming Again, FORBES (July 6, 2013), http://www.forbes.com/sites/brucejapsen/2013/07/06/as-obamacare-rolls-out-retail-clinics-are-booming-again/ (noting the number of retail clinics and urgent care facilities is up 7% from July 1, 2012 to July 1, 2013).
A. A Common Occurrence for Healthcare Providers

Suppose that a hypothetical hospital (for example, HealthyMaker Hospital) wants to buy a new MRI machine. The price of an MRI machine can easily range from $150,000 to $1.2 million. After shopping around, HealthyMaker Hospital decides to buy a General Electric (GE) model that costs $1.2 million. Unfortunately, HealthyMaker Hospital does not have the cash on hand to purchase the new GE MRI machine. HealthyMaker Hospital has a few options: (1) save cash until it can afford to buy the machine, (2) finance the machine through a commercial bank, or (3) finance the machine directly through GE. After researching, HealthyMaker Hospital decides the best way to approach the situation is to finance the purchase through a bank, False National Bank (FNB). FNB commonly lends to hospitals, so it knows the ins and outs of lending, as well as all the risks involved.

As part of the deal, FNB requires collateral from HealthyMaker Hospital to ensure that FNB will have some type of recourse if HealthyMaker Hospital cannot or does not pay. One of HealthyMaker Hospital’s biggest assets that it would be willing to assign is the money owed to it by insurance companies, Medicare, and Medicaid for performing services. To be sure it has access to the proceeds from the payments, FNB requires HealthyMaker Hospital to assign the proceeds over to FNB. The money from the insurance companies is paid directly to a bank account owned by FNB called a “lockbox.”

FNB, however, has run into a problem. HealthyMaker Hospital, who performs services for thousands of Medicare and Medicaid patients, cannot assign the proceeds from Medicaid and Medicare to FNB as a matter of law. This presents a major problem for FNB because HealthyMaker Hospital—like many other healthcare providers—receives a large portion of


8. U.C.C. § 9-102(a)(2) (2013) (“‘Account’ . . . means a right to payment of a monetary obligation . . . (ii) for services rendered or to be rendered . . . .”). Specifically, this type of an account is called a “health-care-insurance receivable.” U.C.C. § 9-102(a)(46) (2013); but see U.C.C. § 9-102 cmt. (5)(i) (excluding receivables under government entitlement programs from the definition of health-care-insurance receivables). The UCC defines these as accounts, but they are commonly referred to as accounts receivable.


its income through Medicare and Medicaid payments. As a solution, HealthyMaker Hospital and FNB agree to have the proceeds paid into a third party bank account in HealthyMaker Hospital’s name. From there, the money will be moved into an account owned by FNB. This system is called a “double lockbox.” Technically, HealthyMaker Hospital and FNB have adhered to the non-assignment laws and still accomplished what would otherwise be illegal.

Although this is a means of getting around the non-assignment problem, this system requires additional monitoring and the need for a third party bank; it creates more work than is truly necessary, as well as some potential problems. For example, because the original deposit account is under control of the debtor, the debtor may make changes to the frequency of the sweeps or prevent them altogether. Also, the debtor could direct the Medicare or Medicaid funds to an entirely different account. If the healthcare provider declares bankruptcy, the lender becomes an unsecured creditor with regard to the Medicare or Medicaid receivables deposit account. If a healthcare provider set up multiple agreements with lenders, each lender would have to worry about such problems. Additionally, one of the parties would have to pay any account fees that accompany the additional account, a cost that is seemingly unnecessary.

---


13. See generally id. (explaining the logistics of circumventing Medicare non-assignment laws).

14. See generally id.

15. See 42 C.F.R. §§ 424.73, 424.90 (2004); Medicare Claims Manual, § 30.2.5 Payment to Bank (June 25, 2004), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf (outlining the requirements for sending payments due to a supplier, a bank, or a similar financial institution).

16. See Medicare Claims Manual, § 30.2.5 (describing that because the debtor/provider has control over the Medicare and Medicaid payments, it could direct the funds in the manner it wishes).

17. BLACK’S LAW DICTIONARY 450 (10th ed. 2014) (defining unsecured creditor as “A creditor who . . . takes no rights against specific property of the debtor.”). The lender’s rights stem from an agreement to have the funds swept into an account controlled by the lender rather than rights to the actual deposit account. Because the Medicare and Medicaid receivables are not assignable and the only way to have a perfected security interest in a deposit account is through control, FNB would not have a perfected security interest in the proceeds of the Medicare and Medicaid payments.

18. See Camin et al., supra note 9.

19. See id.
Courts have recognized that the non-assignment statutes were established, in part, to prevent “factoring.”

Factoring is the purchase of account receivables at a discount, then collecting on them at their face value. A healthcare provider would sell its accounts receivable so that it would have the cash up front, while the factor (buyer of the account) buys the accounts at a discount so that, when the account is paid, the factor receives the full amount.

Not all factoring agreements operate in such a manner. Some factoring agreements consist of the factor lending money to the healthcare provider then collecting their money back from the provider along with a fee. The impact of the non-assignment legislation is felt on traditional lending as well. Although there are other statutes that prohibit other government payments from being assigned, such as payments due resulting from a government contract, there are also exceptions for assigning the payments to banks, trust companies, federal lending agencies, or other financing institutions. The use of a statutory exception from non-assignment in government entitlement programs may make the assignment of Medicare and Medicaid payments a simpler, faster process.

B. Roadmap

This Comment analyzes secured financing from a layman’s viewpoint and additionally discusses how the Uniform Commercial Code (UCC) has evolved to include healthcare insurance receivables, while leaving out Medicare and Medicaid payments. It also recommends changes that could

---

20. In re Missionary Baptist Found., 796 F.2d 752, 757 n.6 (5th Cir. 1986) (“An examination of the legislative history of this provision reveals that its purpose was to prevent ‘factoring’ agencies from purchasing Medicare and Medicaid accounts receivable at a discount and then serving as the collection agency for the accounts. Congress was concerned that direct payment of funds to these factoring agencies was resulting in ‘incorrect and inflated claims.’”) (citing H.R. REP. NO. 92-231 (1971), reprinted in 1972 U.S.C.C.A.N. 4989, 5090).


22. See generally id. (applying the definition to a hypothetical situation).

23. See Wechsler v. Hunt Health Sys., 330 F. Supp. 2d 383, 391 (S.D.N.Y. 2004). The factoring agency would lend 50% of the amount due to the healthcare provider from the insurance agency. Id. When the insurance company paid the healthcare provider, the factoring agency would receive its 50% advancement plus a factoring fee for that account. Id.

24. Id.


27. See generally Camin et al., supra note 9 (explaining the difference between assignable and non-assignable securities).
be made to address this issue. Part II analyzes security interests and healthcare insurance receivables in greater depth. \(^{28}\) Specifically, Part II discusses the effects of secured financing, how the UCC changed to include healthcare insurance receivables, what role Medicare and Medicaid receivables play, and the impact of the Act on the type of lending to keep the discussion as current as possible. \(^{29}\) Part III discusses in more detail how the Act will affect healthcare providers and commercial lenders with regard to secured lending. \(^{30}\) Part IV of this Comment explains why the laws have evolved the way they have and introduces some ways in which those laws could change to increase financing options for healthcare providers. \(^{31}\) Part IV also analyzes various potential changes to non-assignment laws in a way so the reader can understand why there is a recommended added exception to the Medicare and Medicaid anti-assignment clauses. \(^{32}\) Upon reading this Comment, the reader should become more familiar with healthcare financing and should understand why a change is needed in current Medicare and Medicaid laws to better facilitate healthcare providers’ ability to gain financing options.

II. SECURITY INTERESTS AND HEALTHCARE INSURANCE RECEIVABLES

A. Secured Financing Provides Lower Interest Rates in Commercial Lending

A security interest is a property interest created by agreement or by operation of law to secure performance of an obligation, especially repayment of debt. \(^{33}\) Security interests are governed by Article 9 of the UCC and corresponding state laws. \(^{34}\) A security interest in collateral for a loan allows the lender to gain ownership, control, or possession of the collateral in the event of default. The lender’s ability to gain ownership, control, or possession of the collateral in such a case reduces the risk of lending. \(^{35}\) Lower-risk lending leads to lower interest rates for the borrowers. \(^{36}\)

\(^{28}\) See infra Part II.

\(^{29}\) See infra Part II.

\(^{30}\) See infra Part III.

\(^{31}\) See infra Part IV.

\(^{32}\) See infra Part IV.

\(^{33}\) BLACK’S LAW DICTIONARY 1562 (10th ed. 2014).

\(^{34}\) U.C.C. § 9 (2013); TEX. BUS. & COM. CODE ANN. § 9 (West 2012).


\(^{36}\) Id.
Items traditionally used as collateral in a secured loan include equipment, inventory, and accounts, amongst other things.\textsuperscript{37} To be enforceable against the debtor, the security interest must first attach to the collateral.\textsuperscript{38} Under the UCC, a secured lender would also want to perfect its security interest in order to enforce against third parties.\textsuperscript{39} Perfection can be accomplished in various ways depending on the nature of the collateral.\textsuperscript{40} However, a secured lender would be wise to file a financing agreement in the jurisdiction required by the UCC, regardless of the means of perfection. Doing so allows other creditors and lenders to see that the original lender has a security interest in the collateral.\textsuperscript{41}

\textbf{B. Healthcare Insurance Receivables as a Secured Interest}

In 1994, a Virginia Law Review article by Gregory Salathé outlined how allowing healthcare providers—specifically hospitals—to securitize healthcare insurance receivables would reduce the costs of healthcare and provide major benefits to the providers.\textsuperscript{42} In his article, Salathe noted that a specific type of securitization would provide three distinct advantages to hospitals:

First, it will lower dramatically its cost of borrowing. Second, cash on hand will increase, allowing the hospital to operate more efficiently. Finally, securitization will result in a more favorable balance sheet because it is treated as a sale of assets for accounting purposes.\textsuperscript{43}

\textsuperscript{37} U.C.C. § 9-102(a)(33) (defining equipment as “goods other than inventory, farm products, or consumer goods”); U.C.C. § 9-102(a)(48) (including goods other than farm products that are held for sale or lease as well as “raw materials, works in process, or materials used or consumed in the business”); U.C.C. § 9-102(a)(2) (2012) (defining account).

\textsuperscript{38} U.C.C. § 9-203(b) (detailing what must be done to properly attach a security interest). For attachment, there must be value given, the debtor has rights in the collateral or the power to transfer rights, and either an authenticated security agreement, control of the collateral, or possession of the collateral. \textit{Id.}

\textsuperscript{39} Id. § 9-322(a) (stating who has priority and when with conflicting security interests). Some types of property, such as deposit accounts, can only be perfected through control, while others can be perfected through filing a financing statement with the proper state office or merely having possession of the property. In some cases, perfection occurs automatically. \textit{Id.}

\textsuperscript{40} See id. § 9-304 (governing perfection of security interests in deposit accounts). \textit{But see U.C.C. § 9-305} (governing perfection of security interests in letter-of-credit rights).

\textsuperscript{41} \textit{Online Filing and Viewing of U.C.C. Documents, TEX. SEC’Y OF STATE, http://www.sos.state.tx.us/corp/sosda/index.shtml} (last visited Jan. 17, 2014) (allowing an individual to view existing security interest for persons and business). To view secured interests in other states, one would need to follow the procedures set up for that specific state.


\textsuperscript{43} Id. at 554 (specifically mentioning selling accounts receivables to special payment vehicles at a discount, which would in turn sell low-interest commercial paper to investors).
He also noted that hospitals could receive financing at a lower interest rate because lenders would no longer be determining creditworthiness of the hospital but rather of the insurance companies who owed the receivables. 44

In 1999, healthcare insurance receivables were added to the UCC under Article 9. 45 Healthcare insurance receivable “means an interest in or claim under a policy of insurance which is a right to payment of a monetary obligation for healthcare goods or services provided or to be provided.” 46 Prior to the addition of healthcare insurance receivables to the UCC, there was confusion about the treatment of such receivables in commercial law. 47 Since being added to the UCC, healthcare insurance receivables have been afforded somewhat special attention in the UCC, as well as in state commercial codes that differ from the UCC. 48 A security interest in healthcare insurance receivables is automatically perfected upon the assignment of the receivable to the healthcare provider by the patient. 49 In turn, many healthcare providers use healthcare insurance receivables as collateral for obtaining loans. 50 A lender will have to file a financing statement to perfect a security interest in healthcare insurance receivables rather than the automatic attachment with the healthcare provider. 51 Further, in the event of a default, a lender would like to be able to collect the proceeds from the healthcare insurance receivables through any accounts such proceeds may be in. To do this, the lender should take out a lien against the cash and deposit accounts from the healthcare insurance receivables’ proceeds. 52

44. Id. at 555 (“In the case of health care receivables, the third-party payors—made up in large part by the government and private insurers—generally maintain high credit ratings because they are backed by either the full faith and credit of the United States government or a large national insurance company. As a result, the hospital obtains lower interest rates than if investors had to rely on the hospital’s own creditworthiness.”).

45. See U.C.C. § 9-102 cmt. (5)(a) (“The definition of ‘health-care-insurance receivable’ is new. It is a subset of the definition of ‘account.’”).

46. Id. § 9-102(a)(46).


48. See U.C.C. § 9-408 (Restrictions on Assignment of Promissory Notes, Health-Care-Insurance Receivables, and Certain General Intangibles Ineffective); see e.g., TEX. BUS. & COM. CODE ANN. § 9.408 (West 2013). Note that § 9-408(c) is in conflict with Medicare and Medicaid non-assignment clauses as discussed in Part II.C.

49. See U.C.C. § 9-309(5); U.C.C. § 9-309 cmt. 5.

50. Camin et al., supra note 9 (“With certain precautions, a secured lender can include healthcare insurance receivables and accounts as collateral for a loan.”).

51. Id. Typically, a healthcare provider gets assignment of the receivable from the patient, which creates automatic perfection upon attachment. A lender that wishes to get a security interest in the health-care-insurance receivables will have to file the financing statement though.

52. Id.
The secured lender must have “control” of the deposit account in order to perfect a security interest in the deposit account and the money in the deposit account. Control exists if: (i) the secured lender is the depository bank at which the debtor maintains its deposit account; (ii) the secured lender becomes the depository bank’s customer with respect to the deposit account; or (iii) the secured lender enters into a deposit account control agreement with the depository bank.53

C. Gaining Security Interests in Government Entitlement Programs Such as Medicaid

The UCC does not cover government entitlement programs.54 Additionally, Medicaid and Medicare receivables are not assignable.55 Some courts, however, have ruled that despite non-assignment clauses, Medicaid payments can be used as collateral so long as they comply with non-assignable statutes.56 In order for a Medicaid payment to comply with a non-assignable statute, (1) the Medicaid payments must be made to the healthcare provider, (2) the bank to which payments are deposited into are not controlled or acting on behalf of a lender, (3) the healthcare provider has sole control of the account, and (4) only the provider can provide standing instructions regarding the account.57 In order to conform to the non-assignment statutes, lenders and healthcare providers have set up what is commonly called a “double lockbox” system.58 A double lockbox system occurs when the Medicaid funds in a deposit account are “swept” into an account controlled by the lender who has a perfected security interest.59 A sweep is typically completed daily in order to guarantee immediate control.60 The double lockbox system is not needed for attachment or perfection but is merely a practical way for the lenders to gain access and control to the Medicaid payments.61 Attachment should be done through a proper security agreement, while perfection should be completed through the filing of a financing statement.62

53. Id.
55. TEX. HUM. RES. CODE ANN. § 32.036 (non-assignment clause for Medicaid in Texas); 42 U.S.C. §§ 1396 et seq. (Medicaid statutes); 42 U.S.C. § 1395g(e) (Medicare non-assignment clause).
56. In re Missionary Baptist Found., 796 F.2d 752, 757 n.6 (5th Cir. 1986).
58. See id.; Camin et al., supra note 9; Center for Medicare and Medicaid Intermediary Manual § 3488.
59. Smith & Jones, supra note 57.
60. See Smith & Jones, supra note 57; see also Camin et al., supra note 9.
61. Camin et al., supra note 9.
62. Id. (“With certain precautions, a secured lender can include healthcare insurance receivables and accounts as collateral for a loan.”).
Other courts, on the other hand, have given a different interpretation of non-assignment clauses. In *Credit Recovery Systems, LLC v. Heike*, Heike had assigned his Medicare and Medicaid receivables to Credit Recovery Systems as collateral for a loan. In an unrelated case, Heike was charged with violating the False Claims Act. Heike settled with the government, forfeiting all claims to any unpaid Medicare or Medicaid receivables. Credit Recovery Systems brought a suit against Heike, arguing that he could not forfeit those claims since they did not belong to Heike and asked the court to validate the assignment. The United States intervened and motioned for summary judgment, arguing that the court could not validate the assignment, only contemporaneously assign the receivables. The court analyzed an exception to the non-assignment clause that allows a court to establish an assignment of Medicare or Medicaid payments. The court also analyzed the Medicare Carrier’s Manual, which stated that a court could validate a previous assignment agreement. The court ultimately sided with intervener United States, holding that “Medicare Carrier’s Manual is neither a statute nor regulation” and that “[b]oth the statute and the regulations require that an assignment to be valid must be made ‘by or pursuant to’ a court order.” Essentially, the court held that if a debtor and lender wish to assign the direct payment of Medicare or Medicaid receivables to the lender, they must obtain a court order to do so. Such an inconvenience simultaneously encourages litigation and discourages Medicare or Medicaid assignment agreements.

63. See *Credit Recovery Systems, LLC v. Heike*, 158 F. Supp. 2d 689, 694–96 (E.D. Va. 2001). The court determined that according to the non-assignment clauses, the only way an assignment could be made is if a court of competent jurisdiction contemporaneously creates an assignment. *Id.*
64. *Id.* at 690.
65. *Id.* at 691 (Heike was charged with providing services that were deemed unnecessary).
66. *Id.* Credit Recovery Systems had attempted to intervene in the fraud and abuse case.
67. *Id.* at 691–92. As per their financing agreement, Heike had assigned the Medicare and Medicaid payments to Credit Recovery Systems, thus forfeiting his claim. *Id.*
69. *Id.* (citing 42 U.S.C. § 1395g(e) (allowing assignment to “government agency or entity or is established by or pursuant to the order of a court of competent jurisdiction”)).
70. *Id.* (citing Medicare Carriers Manual, Part 2, Chapter 4, § 5304).
71. *Id.* at 695.
72. *Id.* at 696 (noting that the receivable may be assigned to a spouse collecting child support by court order).
73. In order to establish a proper assignment, both parties must have a court order for the assignment. *Id.* There is nothing to suggest that a court will freely order such an assignment. *Id.* Additionally, because of the additional costs and lack of guarantee, lenders are not likely to consider the assignment altogether. *Id.*
D. The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act was passed on March 23, 2010, and is codified as Public Law 111-148. The Act contains well over nine hundred pages. It is the largest piece of legislation affecting healthcare in the United States since the Medicare and Medicaid acts. The Act is also a very controversial piece of legislation. Perhaps the most controversial part of the Act is the individual mandate.

There are some exemptions to the individual mandate. Those individuals that do not maintain the minimum level of insurance after January 1, 2014, as required by the Act (defined in 42 U.S.C. § 18021) will be subject to tax penalties for themselves and any of their dependents. Individuals who are 133% of, or below, the poverty line will have health insurance subsidized to them through Medicaid. Other major changes include: increasing the dependency age to twenty-six, filling gaps in Medicare, guaranteed coverage, and requiring employers with two hundred or more employees to offer qualified healthcare insurance plans to their employees. There is an additional change that allows a refundable tax credit for individuals under 400% of the poverty line. The refundable tax credit is subject to income tiers to determine the applicable percentage.

---

75. Id.
76. See Siegel, supra note 5.
77. See generally id. (stating 83% of physicians have considered leaving the practice of medicine); Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (holding a challenge to the Act is unconstitutional on multiple grounds).
78. See generally 26 U.S.C. § 5000A (2013) (requiring all individuals not excluded from the bill to maintain a minimum level of healthcare coverage defined in the Act).
80. 26 U.S.C. § 5000A. The penalty for individuals is $95 in 2014, $365 in 2015, and $695 (adjusted for inflation) in 2016 and beyond. This is applied on a monthly basis by multiplying the penalty by one twelfth for every month not covered.
84. Id.
In passing the Act, Congress found that “[t]he [individual mandate], together with other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, healthcare services . . . .” Congress predicts that national health spending will increase by $2.2 trillion from 2009 to 2019. Many healthcare providers believe these major changes to the healthcare insurance system will be bad for the healthcare industry. In fact, some major healthcare providers, such as hospitals, are laying off employees in fear of lost profits. However, unpaid medical bills have jumped to an all-time high of $41.1 billion in 2011. Much of that amount is attributable to write-offs of unpaid bills from patients without insurance. Fortunately, with the passing of the Act, hospitals should see this number drop substantially beginning in 2014. Due to the expected increase in demand for healthcare, an increase in spending, expanded coverage, and fewer write-offs, hospitals should also see a large increase in accounts receivable from private healthcare insurance plans, as well as Medicaid. Increased revenues and accounts in healthcare insurance receivables will provide hospitals with greater financing options.

III. ADDING PPACA HEALTHCARE INSURANCE PLANS INTO THE MIX OF CURRENT TREATMENT

A. Benefits of the Effects of the PPACA to Healthcare Providers

It is likely that many individuals and families will choose to purchase and maintain the minimum level of healthcare insurance coverage required

85. 42 U.S.C. § 18091(2)(C) (2013). The individual mandate, expansion of Medicaid, and increasing the age of insurance dependency to twenty-six are likely to have the greatest effect on the increase of insured individuals.
86. See id. at § 18091(2)(B).
87. Siegel, supra note 5 (stating 90% of physicians believe the healthcare industry is headed in the wrong direction).
89. Japsen, supra note 6.
90. Id.
91. See id. Since millions of previously uninsured Americans will now be participating in private insurance plans or Medicaid as well as the expansion of Medicare, hospitals should expect to see people who previously had not paid to be paid for on behalf of these plans.
92. See id.
93. See id.
by the Act.\textsuperscript{94} According to the United States Census Bureau, in 2011, approximately 48.6 million Americans did not have health insurance.\textsuperscript{95} According to the Bureau of Labor Statistics, the average American spent approximately $3,313 on healthcare in 2011.\textsuperscript{96} If approximately 50\% of the uninsured population becomes insured either through private insurance plans or Medicaid, the insured population will increase by 24.3 million.\textsuperscript{97} Because of the large increase in insurance coverage, more Americans are likely to access healthcare.\textsuperscript{98} Accordingly, revenues will increase and write-offs will decrease, as discussed earlier.\textsuperscript{99} It is important to note that most of the revenues will be realized through accounts receivables rather than through cash.\textsuperscript{100} There are many states that have opted not to expand Medicaid.\textsuperscript{101} Texas, a state that elected not to expand Medicaid, is projected to see a 35\% reduction in uninsured but would see a projected 52\% drop with the expansion of Medicaid.\textsuperscript{102} At the end of February 2014, an additional three million individuals have enrolled in Medicaid or CHIP.\textsuperscript{103} Accounts receivables are typically recovered between thirty and ninety days after being issued, rather than realized immediately like cash.\textsuperscript{104} Because of this, healthcare providers should see a large increase in the

\begin{footnotes}
\item[94] Although 2014 and 2015 penalties will be relatively low, it would be wise for individuals to purchase insurance as to make a gain in the money spent, rather than seeing it go to waste through penalties. Additionally, those who do purchase insurance will receive various tax benefits as outlined in the Act.
\item[97] \textit{State Participation in the Affordable Care Act’s Expansion of Medicaid Eligibility}, THE COMMONWEALTH FUND (August 2013), http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx (hereinafter \textit{State Participation}). Reducing the uninsured by 50\% seems to be an optimistic figure. Some states may see a only a 25–30\% reduction in uninsured patients while others may see a reduction rate as high as 60\%. It is important to note that these figures are projections and that true figures may not be known for quite some time.
\item[99] Japsen, supra note 6.
\item[100] Cash is immediately available for the provider to use in business expenses such as salaries, overhead, and purchasing equipment or inventory. Accounts receivable, on the other hand, are not available for use until the party that owes the debt pays them.
\item[101] State Participation, supra note 97 (showing that twenty states have decided not to expand Medicaid while twenty-three states decided to expand Medicaid under the Act, four are expanding it in a customized way, and four are undecided).
\item[102] \textit{Id}.
\end{footnotes}
accounts receivable (either through healthcare insurance receivables, Medicaid, or Medicare) on their books. Although increased revenues are good, one downfall is the inability to use the revenues immediately for business operations, expansions, maintenance, salaries, etc.\textsuperscript{105} One way to combat this delay in realization is for healthcare providers to use their healthcare insurance receivables as collateral in secured financing.\textsuperscript{106} Because the healthcare provider’s accounts are so inflated, the risk to the lender will be much lower, thus making it more likely for a lender to offer lower interest rates.\textsuperscript{107} The healthcare provider will then have funding to support its business operations.\textsuperscript{108} This type of lending can be referred to as “factor lending.”\textsuperscript{109}

\textbf{B. Effect of PPACA on Commercial Lenders}

Banks that lend to businesses often have a security interest when they lend large amounts of capital.\textsuperscript{110} Although the healthcare industry is growing, a lender would still prefer to have its loans secured by an interest in healthcare receivables in the event of default due to nonpayment or bankruptcy.\textsuperscript{111} A “lockbox” system allows the lender to gain control of insurance proceeds by having them deposited directly into an account controlled by the lender.\textsuperscript{112} The lockbox system guarantees that lenders will have access to and control over the funds.\textsuperscript{113} If properly attached and perfected, lenders often prefer control through the lockbox system.\textsuperscript{114}

\begin{itemize}
  \item \textsuperscript{105} Id. (discussing the advantages and disadvantages of having accounts receivable as opposed to cash).
  \item \textsuperscript{106} Andrea C. Barach & Wendy A. Chow, \textit{FHA Insured Loans for Long Term Healthcare Facilities: Recent Developments as a Popular Product Evolves to Meet Growing Needs}, 25 No. 5 \textit{HEALTH LAW} 1, 15–17 (June 2011).
  \item \textsuperscript{107} See Robert E. Scott, \textit{A Relational Theory of Secured Financing}, \textit{86 COLUM. L. REV.} 901, 908 n.27 (1986) (discussing how secured loans affect interest rates in relation to non-secured loans). \textit{See also} Mann, \textit{supra} note 35, at 638–39 (explaining “the benefits and burdens of secured credit”).
  \item \textsuperscript{108} See Barach & Chow, \textit{supra} note 106, at 6 (explaining how the amount of funding is calculated).
  \item \textsuperscript{110} Mann, \textit{supra} note 35, at 638–39 (explaining “the benefits and burdens of secured credit”).
  \item \textsuperscript{112} Camin et al., \textit{supra} note 9.
  \item \textsuperscript{113} \textit{See id.}
  \item \textsuperscript{114} \textit{See id.}
\end{itemize}
As discussed earlier, Medicaid and Medicare payments are non-assignable per statute. Lenders must instead utilize the double lockbox system with regards to Medicaid and Medicare receivables. Because of the requirements set out by CMS Intermediary Manual § 3488, a lender and healthcare provider will need to have an agreement with a third party bank. The funds in deposit accounts with the third party bank will be swept into an account controlled by the lender—most likely on a daily basis—so that the lender can gain access to the funds while conforming to the non-assignment statutes.

Although factor lending is a common type of financing that lenders may participate in with regard to healthcare insurance receivables, it is meant to be a short-term type of lending. The government has frowned upon factoring in the past. Many lenders loan money to healthcare providers on a long-term basis for expansion, research, or purchases of expensive medical equipment, such as MRI machines. Long-term lenders are likely to get a security interest in healthcare insurance receivables, including Medicaid and Medicare. Because the only way to perfect a security interest in deposit accounts is through control, only one secured party will be able to perfect its interest in the Medicaid and Medicare receivables. In the event of bankruptcy, any excess funds that are in control of the party will move to unsecured creditors instead of secured creditors. Although lenders will still be able to have private healthcare insurance receivables assigned directly to them, they may be missing out on a large piece of collateral in Medicaid and Medicare payments.

115. TEX. HUM. RES. CODE ANN. § 32.036 (Vernon 2013); 42 U.S.C. §§ 1396 et seq; 42 U.S.C. § 1395g(c).
116. See Smith & Jones, supra note 57. See also Camin et al., supra note 9; Barach & Chow, supra note 106, at 15–17 (further discussing the mechanics of lockbox and double lockbox systems for Medicaid and Medicare receivables).
117. See Smith & Jones, supra note 57. See also Camin et al., supra note 9.
122. See id.
123. U.C.C. § 9-304 (2010). Of course, not all Medicare and Medicaid payments have to go to one account for a lender. But other agreements with different accounts require more bank agreements, tracing which payments go into which account, and other additional administrative difficulties and costs that accompany each agreement.
IV. PROPOSED CHANGE TO NON-ASSIGNMENT STATUTES

A. Reasoning Behind Non-Assignment Statutes

According to Congress, the original intent behind non-assignment clauses is to "prevent 'factoring' agencies from purchasing [M]edicare and [M]edicaid accounts receivable at a discount and then serving as the collection agency for the accounts. Congress was concerned that direct payment of funds to these factoring agencies was resulting in 'incorrect and inflated claims.'" 125 Factoring has "created administrative problems with respect to determinations of reasonable charges and recovery of overpayments." 126 Specifically, Congress found that "[f]raudulent operations of collection agencies have been identified in [M]edicare" and that "[s]ubstantial overpayments to many such organizations have been identified in the [M]edicare program, one involving over a million dollars." 127 In 1977, Congress sought to strengthen the non-assignment clauses to prevent providers from using powers of attorney to circumvent the existing ban on the use of factoring arrangements. 128 But with the double lockbox system, factoring agencies have been able to continue factor lending on Medicare and Medicaid receivables despite the non-assignment clause. 129 An ancillary effect of the non-assignment clauses, however, was preventing healthcare providers from assigning the receivables for traditional financing purposes. 130 It is important to note that Congress has not established any legislation that prevents the double lockbox system currently used by providers and lenders. 131 Additionally, the federal and

---

126. H.R. REP. NO. 95-393. ("The Committee’s bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of ‘factoring’ arrangements in connection with the payment of claims by the [M]edicare and [M]edicaid programs.”).
128. H.R. REP. NO. 95-393 (“The Committee’s bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of ‘factoring’ arrangements in connection with the payment of claims by the [M]edicare and [M]edicaid programs.”).
129. 1st Commercial Credit, Question and Answer Section, http://www.1stcommercialcredit.com/factoring-finance-and-asset-based-lending-for-medical-receivables/ (last updated 2013) (explaining that the company sets up a lockbox in the healthcare provider’s name in order to get around non-assignment of Medicare and Medicaid). Of course, with the lockbox system, tracking payments and overpayments is still relatively simple because the payments are made to the healthcare provider and forwarded to the factoring agency.
130. See Camin et al., supra note 9. One example of such an effect is the inability for healthcare providers to assign payments directly to lenders in a secured transaction.
131. See id.
state governments constantly bring suits against medical providers for fraudulent Medicare or Medicaid payments.132 

The type of factoring agreement in Wechsler v. Hunt Health System would likely not have created the type of administrative problems found when Congress prohibited assignments.133 The factoring agency only lent money to the healthcare provider and collected an account fee; the healthcare insurance receivables were always paid to the healthcare provider.134 This type of factoring could easily be allowed as a lending type to healthcare providers, even with Medicare and Medicaid, because the government would not have an issue of not knowing who to collect overpayments from.135 Of course, the factoring agency likely would wish to have a security interest and assignment in the Medicare or Medicaid receivables in the event of default or breach of contract.136 One issue with such a type of lending, however, is that lenders may use a part of every Medicare and Medicaid payment (government money) as a financing fee rather than for medical costs as intended.137

B. Change to the Non-Assignment Statutes

1. Creating an Exception to the Non-Assignment Statutes

The federal government also prohibits assignment of funds payable by the government in other situations.138 There is, however, an exception to assigning payments “to a bank, trust company, federal lending agency, or

132. See Merrill Matthews, Medicare and Medicaid Fraud Is Costing Taxpayers Billions, FORBES (May 31, 2012), http://www.forbes.com/sites/merrillmatthews/2012/05/31/medicare-and-medicaid-fraud-is-costing-taxpayers-billions/2 (“Federal authorities boast of recovering $4.1 billion in 2011 from fraudulent activity, but again spent millions of dollars to recover it.”). Because the federal and state governments are spending so much on prosecuting fraud cases, finding a way to expand lending and eliminating a type of fraud altogether would likely be beneficial to both government and industry.


134. Id.


136. Mann, supra note 35, at 638–39 (explaining “The Benefits and Burdens of Secured Credit”). See supra text accompanying note 25. Depending on the jurisdiction, to get a valid assignment of Medicare and Medicaid receivables, the parties may have to have a court of competent jurisdiction validate the assignment before it becomes effective.

137. See Wechsler, 330 F. Supp. 2d at 389 (stating that the factoring agency paid 50% to the provider until the full amount was paid to the provider by Medicare or Medicaid, at which point the factoring agency received 50% plus a fee for the advancement). Thus, the hospital is paying money to the factoring agency that the hospital received from Medicare or Medicaid.

138. 41 U.S.C. § 6305(a) (2013) (“The party to whom the Federal Government gives a contract or order may not transfer the contract or order, or any interest in the contract or order, to another party.”).
other financing institution.” Of course, the statutory exception contains certain requirements to be met before the assignment is valid.

Medicare and Medicaid could have similar exceptions to their respective non-assignment clauses. Establishing such an exception would allow healthcare providers to assign Medicare and Medicaid receivables directly to long-term lenders. With the ability to directly assign government entitlement payments, healthcare providers and lenders would no longer need to take the extra steps currently required to avoid violating non-assignment clauses. Reducing the steps required to successfully assign Medicare and Medicaid payments would allow healthcare providers to streamline their process, rather than having a separate process for private healthcare insurance receivables and Medicare and Medicaid receivables.

With the massive changes in the healthcare field and technological advances, another option to consider is to allow factoring while eliminating the anti-assignment clauses altogether. Since the 1970s, there have been many technological advances that would make it much easier to track fraudulent claims. Originally, Congress believed that most of the fraudulent claims could be traced back to nursing homes. Perhaps another option is to create exemptions for specific types of healthcare providers, such as only those that provide diagnostic or disease treatment services. Allowing factoring is likely not the best option. One of Congress’s primary reasons for passing the anti-assignment clauses was to

---

139. Id. § 6305(a)(1).
140. Id. § 6305(a)(2) (stating that the amount due from the government must be at least $1000.00); id. § 6305(a)(3) (stating that the contract cannot forbid assignment); id. § 6305(a)(4) (stating that the assignment must cover all amounts due from the federal government under the contract); id. § 6305(a)(5) (stating that the assignment may not be made to more than one party unless otherwise stated in the contract); id. § 6305(a)(6) (stating that the assignee shall provide written notice and a true copy of the instrument of assignment).
141. Sometimes the inaction of Congress can be interpreted that Congress has approved of the methods and means being utilized, especially in an area of law that has been regulated in the past. Although we do not know if Congress approves of using the double lockbox system to use Medicare and Medicaid receivables as collateral, one must wonder if Congress has not acted because it is satisfied with the receivables being used as collateral now.
142. Id. § 6305(a)(9).
143. Id.
144. See Zirkle, supra note 25, at 394 (“The anti-assignment provisions, enacted to curb the abuses of factoring agencies, are no longer necessary in the world of modern lending practices.”). 145. See Matthews, supra note 132 (“Obamacare allows the Department of Health and Human Services (HHS) to step away from its ‘pay and chase’ model—where Medicare and Medicaid routinely paid every bill that comes in and only goes after someone if it’s blatantly obvious that something was wrong . . . .”). Also, much, if not all, of the record keeping is done electronically, making payments much easier to track.
147. Nursing homes and assisted living facilities do not usually provide diagnostic or disease treatment services apart from administering prescription medication.
reduce the administrative difficulties in collecting overpayment and fraudulent payments.\(^{148}\) The new movement of Medicare and Medicaid payments involves payments based on patient satisfaction and other factors rather than services rendered.\(^{149}\) To implement the new system, Medicare and Medicaid will withhold 1% of each payment from healthcare providers.\(^{150}\) The amounts withheld will then be used to pay bonuses to hospitals that achieve higher-than-average scores for a specific fiscal year.\(^{151}\) The bonuses will encourage healthcare providers to reach certain benchmarks and score higher-than-average satisfaction ratings on a number of measurements.\(^{152}\) This additional system of withholding and paying out bonuses creates another opportunity for overpayments to be made, necessitating the need for a recall of such payments.\(^{153}\) The ability to freely assign payments will create yet another difficulty in determining from whom to collect overpayments.\(^{154}\)

2. **Eliminating the Anti-Assignment Statutes Altogether**

One scholar believes that the non-assignment statutes should be eliminated altogether.\(^{155}\) She suggests that if eliminating non-assignment statutes is not feasible, “Congress could redraft the Medicare judicial remedies to allow courts to validate assignment orders after-the-fact.”\(^{156}\) While allowing a court to validate Medicare receivable assignments could

---

149. See 42 C.F.R. §§ 422, 480 (2013). See also Jordan Rau, Medicare To Begin Basing Hospital Payments On Patient-Satisfaction Scores, KAISER HEALTH NEWS (Apr. 28, 2011), available at http://www.kaiserhealthnews.org/stories/2011/april/28/medicare-hospital-patient-satisfaction.aspx (explaining that money will be withheld from providers that do not maintain an average score and bonuses paid to providers that score above average on several measures). This type of payment system is known as “pay for quality” (P4Q) as opposed to the old system referred to as “pay for performance” (P4P).
150. Rau, supra note 149.
151. Id.
152. See 42 C.F.R. §§ 422, 480; see also Rau, supra note 149.
153. See Rau, supra note 149. By recalling paid amounts as penalties and paying more for bonuses, there is a new opportunity for over and underpayments.
155. See Zirkle, supra note 25, at 394–96 (suggesting change of the Medicare statute by removing non-assignment would benefit healthcare providers by expanding the borrowing base to include Medicare receivables). Although Zirkle only specifically addresses Medicare non-assignment, the same can likely go for Medicaid payments, especially with the changes being brought by the Act.
156. Id. at 395 (opposing the requirement that courts must validate the assignment contemporaneously as held in Credit Recovery Systems, LLC v. Heike, text accompanying notes 50–60).
be a feasible option, it would require parties to initiate judicial proceedings to validate the assignment, creating yet another step in the process of enforcing a security interest.\textsuperscript{157} Zirkle appropriately notes that the Medicare non-assignment statute prevents the receivables from being included in the borrowing base for lending.\textsuperscript{158} However, eliminating the non-assignment statute altogether could create additional problems for governments. For example, if the federal and state governments wished to keep factoring of Medicare and Medicaid receivables to a minimum, there would be no recourse for factoring without extensive laws against it.\textsuperscript{159} Additionally, allowing a healthcare provider to assign its Medicare and Medicaid receivables could open floodgates as to who would receive such assignments and from whom to collect overpayments.\textsuperscript{160} Without considering whether it violates STARK, Anti-kickback, or other statutes, a provider may even be able to assign Medicare and Medicaid payments to pay its employees.\textsuperscript{161}

3. Outlawing or Regulating Double Lockbox Systems

Taking a step in the opposite direction, Congress and state legislatures could enact laws that prohibit double lockbox systems.\textsuperscript{162} Although the double lockbox system keeps the payments in the name of the healthcare provider to whom the payments are owed, they are almost immediately moved to the control of lenders and factoring agencies.\textsuperscript{163} Congress said that one of the biggest difficulties it has faced when assignments were

\textsuperscript{157} Id. ("Medicare judicial proceeding would simply serve to validate the assignment, making the assignment of receivables a certainty rather than a mere possibility."). However, allowing a court to validate an assignment post hoc does not necessarily make it a certainty that it will do so.

\textsuperscript{158} Id. at 390 ("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.") (citing Salathe, supra note 42).

\textsuperscript{159} 1st Commercial Credit, Question and Answer Section, (Jan. 16, 2014), http://www.1stcommercialcredit.com/factoring-finance-and-asset-based-lending-for-medical-receivables/. Factoring agencies have found ways to continue lending despite non-assignment clauses using the double lockbox system.


\textsuperscript{161} See Credit Recovery Systems, 158 F. Supp at 696. If the spouse would be able to assign payments for child support, it is feasible that the provider could use the assignments to pay employees. Assigning payments to pay employees would be highly unlikely and would probably violate other statutes, but with free-ranging ability to assign Medicare and Medicaid payments, this is an issue that the government would have to keep track of.

\textsuperscript{162} As stated in Part IV.A, there is no legislation prohibiting the use of double lockbox systems to circumvent non-assignment clauses.

\textsuperscript{163} Camin et al., supra note 9.
allowed was collecting overpayments and fraudulent payments.\textsuperscript{164} When the payments are moved to an account not controlled by the healthcare provider but were paid to the healthcare provider, the government will face the same difficulties that it had in 1972 when enacting the anti-assignment statutes.\textsuperscript{165} The factoring method used in Wechsler v. Hunt Health Systems keeps all payments made to healthcare providers under the control of healthcare providers, while still allowing the provider to use a portion of the receivables as necessary.\textsuperscript{166} If the Medicare and Medicaid receivables were assignable, the factoring agency could use the ordinary lockbox system in the case of default, but both the healthcare provider and factoring agent could have control in case the government needed to collect overpayments.\textsuperscript{167}

Another possibility is that Congress could allow the double lockbox but place the responsibility of tracking where the funds have gone on the healthcare providers and other parties involved.\textsuperscript{168} Doing so would also necessitate agreements to specify that all funds be subject to recovery by the government in the event of any overpayments or fraudulent payments.\textsuperscript{169} Regulation of the double lockbox system would advance the purpose of the non-assignment clauses while still allowing healthcare providers to use Medicare and Medicaid receivables for borrowing and security agreements.\textsuperscript{170}

\textbf{C. Problems Arising from an Exception to the Non-Assignment Clauses}

Although many problems may exist in enacting a non-assignment exception, one of the most obvious is that even though the assignee is a bank, the assignment could still be created for the purposes of factoring.\textsuperscript{171} To combat this, the exception would undoubtedly need to contain an

\begin{itemize}
  \item \textsuperscript{164} H.R. REP. NO. 92-231 (Factoring has “created administrative problems with respect to determinations of reasonable charges and recovery of overpayments.”).
  \item \textsuperscript{165} Id.
  \item \textsuperscript{166} See Wechsler v. Hunt Health Sys., 330 F. Supp. 2d 383, 389 (S.D.N.Y. 2004). The factoring agency paid 50\% to the provider until the full amount was paid to the provider by Medicare or Medicaid, at which point the factoring agency received 50\% plus a fee for the advancement. Id.
  \item \textsuperscript{167} See Smith & Jones, supra note 57 (stating that currently, the deposit account must be in the name of and controlled by the care provider). Without the anti-assignment requirement, the lender could also have control over the deposit account.
  \item \textsuperscript{168} H.R. REP. NO. 92-231 (Factoring has “created administrative problems with respect to determinations of reasonable charges and recovery of overpayments.”). Creating a system of accountability will reduce the administrative difficulties when recovering overpayments.
  \item \textsuperscript{169} Id.
  \item \textsuperscript{170} In re Missionary Baptist Found., 796 F.2d 752, 757 n.6 (5th Cir. 1986). The reasoning behind non-assignment was to reduce overpayments and ease administrative difficulties. See id. Tracking the payments would shift the burden to the parties involved in the agreements and create accountability for overpayments. See id.
  \item \textsuperscript{171} 41 U.S.C. § 6305(a)(2) (2013).
\end{itemize}
exception to the exception that assignment shall not be used for the purposes of factoring.\textsuperscript{172} Although this would not necessarily prevent disguised factoring agreements, it would allow the government recourse if it determines the assignment is for the purpose of factoring.\textsuperscript{173} The prohibition on assignment purely for the use of factoring presents an additional problem: determining, as a matter of fact, whether the assignment was for the purpose of factoring.\textsuperscript{174} Governments already spend millions of dollars tracking fraudulent or abusive Medicare and Medicaid claims.\textsuperscript{175} If assignment is allowed but factoring is still prohibited, investigators may spend more time—and, thus, more money—trying to determine whether a certain assignment is for the purpose of factoring.\textsuperscript{176} With factor lending being used on Medicare and Medicaid receivables, essentially a portion of each of the payments is going towards financing early payments.\textsuperscript{177} Allowing healthcare providers to assign Medicare and Medicaid receivables to secure financing, but preventing factoring, will expand the provider’s use of the receivables while limiting the administrative difficulties that come with factoring.

A second major problem that could arise with allowing assignments is the increased difficulty in tracking payments.\textsuperscript{178} State and federal agencies will have to determine if the proper payment was made to the intended party for the services performed by a separate entity.\textsuperscript{179} There may also be fraudulent assignments of payments to assignees, which the assignor never actually agreed to. Adding this additional level of tracking will likely increase the amount of man hours that would go into investigating claims, thus increasing the cost incurred by government agencies.\textsuperscript{180}

\begin{itemize}
  \item \textsuperscript{172} H.R. REP. NO. 92-231. Factoring was the issue of millions of dollars of fraudulent claims prior to the non-assignment clauses.
  \item \textsuperscript{173} There would need to be a penalty, whether it is monetary or otherwise, for assignment of payments for the purposes of factoring.
  \item \textsuperscript{174} This additional level of proof may create more hurdles for the government to jump over if they were to prosecute such cases.
  \item \textsuperscript{175} See Matthews, supra note 132.
  \item \textsuperscript{176} Id. With the government already spending so much on tracking fraud and abuse cases, creating additional cost burdens would have to be weighed against the potential benefits.
  \item \textsuperscript{177} See Wechsler v. Hunt Health Sys., 330 F. Supp. 2d 383, 390–91 (S.D.N.Y. 2004) (explaining that the factoring agency collected a fee on each account). Having a portion of government money going to financing costs rather than healthcare can be particularly troubling in light of the federal deficit and the recent passing of the Act to lower healthcare costs.
  \item \textsuperscript{178} H.R. REP. NO. 92-231 (1971), reprinted in 1972 U.S.C.C.A.N. 4989, 5090 (Factoring has “created administrative problems with respect to determinations of reasonable charges and recovery of overpayments.”).
  \item \textsuperscript{179} See id. For example, if a hospital had assigned its receivables to a bank, the agency will have to determine whether the services were actually (and properly) rendered to the patient, and if payment should actually be paid to the bank.
  \item \textsuperscript{180} See Matthews, supra note 132. A full cost-benefit analysis should be done to determine how much, if any, costs would increase or decrease both immediately and over time.
\end{itemize}
V. CONCLUSION

Healthcare providers are under constant pressure to adhere to ever-changing laws, patient expectation, and ethical guidelines, while still operating a successful business and providing the best possible care to their patients. Healthcare providers are constantly looking to expand, discover the next big innovation, conduct research, and meet the demand for their services. The laws that require them to adhere to very specific financial standards have created some obstacles when looking to make financial gain or use their resources in the best way possible. It is time some of the outdated and even useless laws change with the times.\footnote{181. See generally Camin et al., supra note 9 (explaining the double lockbox system). The non-assignment clauses do not prevent lenders from using the double lockbox system to circumvent the law. They have, however, increased the cost and administrative difficulties in using the Medicare and Medicaid receivables as collateral for loans.}

Because the current methods being used potentially create the same problems as when Congress enacted the non-assignment clauses, the clauses should have exceptions added to them that allow healthcare providers to use the Medicare and Medicaid receivables to their advantage in more ways. Creating the exceptions outlined in this Comment would allow healthcare providers to use the healthcare receivables in a way they are already used but without the additional steps currently used to side step the non-assignment statutes.\footnote{182. See id. (The receivables are paid to the healthcare provider but almost immediately moved to the control of a lender via the double lockbox system.).} Although multiple alternatives exist, each with its own set of advantages and disadvantages, carefully drafting exceptions to non-assignment clauses and outlawing specific types of factoring appears to be the most beneficial for not only the government but also for healthcare providers and lenders of all types. If the type of factoring used in \textit{Wechsler v. Hunt Health Systems} was the only type allowed, factoring agencies could still operate but in a way that reduces administrative difficulties for the government.\footnote{183. See \textit{Wechsler v. Hunt Health Sys.}, 330 F. Supp. 2d 383, 389 (S.D.N.Y. 2004). The factoring agency loaned 50\% of the receivable to the healthcare provider. Upon the healthcare provider receiving payment from the debtor, the provider would pay the advancement back to the agency with an additional factoring fee.} Additionally, creating an exception to non-assignment clauses, while simultaneously allowing the specific type of factoring, will free Medicare and Medicaid receivables to be used to their full potential in healthcare financing.

Undoubtedly, problems arise when implementing new laws.\footnote{184. H.R. Rep. No. 95-393 (1977), reprinted in 1977 U.S.C.C.A.N. 3039, 3051–52 (“The Committee’s bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of ‘factoring’ arrangements in connection with the payment of claims by the [M]edicare and [M]edicaid programs.”). After implementing the first non-assignment law} However, the healthcare industry is rapidly changing.\footnote{185. It is time for some}
of the restrictions that have been placed on healthcare financing to change with the times so that lenders and healthcare providers alike can take full advantage of the range of options that exist. The government needs to respond to the methods utilized by lenders while still advancing its goal of lowering healthcare costs. Allowing healthcare providers to use all possible methods to gain as much financing as possible at the lowest rate available should help reduce the costs of healthcare.\textsuperscript{186}

\footnotesize{\textsuperscript{186} In 1972, lenders found a way around it by using a power of attorney. Congress has not had the same reaction with regards to the double lockbox system. See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2013) (codified in scattered sections of 26 U.S.C.); Rau, supra note 149.\textsuperscript{185} Salathe, supra note 42, at 555 ("In the case of health care receivables, the third-party payors—made up in large part by the government and private insurers—generally maintain high credit ratings because they are backed by either the full faith and credit of the United States government or a large national insurance company. As a result, the hospital obtains lower interest rates than if investors had to rely on the hospital’s own creditworthiness.").}