FINDING RESIDENT VOICE IN HOSPITAL BANKRUPTCIES

by

B. Summer Chandler*

Hospital bankruptcies are not merely private disputes between distressed debtors and their creditors. Hospital distress can threaten access to essential health care services, disrupt local economies, and alter the future of institutions on which communities depend. Drawing on Professor Juliet Moringiello's scholarship on municipal bankruptcy, this article argues that hospital bankruptcies raise governance concerns similar to those present in municipal insolvency, where federal bankruptcy relief operates within a state-federal partnership that preserves a significant role for state and local governance. Hospital bankruptcy, though more frequently pursued under chapter 11 than chapter 9, likewise implicates state police powers, public health policy, and residents' ability to participate in decisions affecting critical health care resources in their communities.

This article examines hospital bankruptcy cases under chapters 9 and 11 to assess how resident voice is preserved, muted, or displaced when financially distressed hospitals restructure, sell assets, or close. It argues that the protection and expression of resident voice depend in important respects on both the hospital's legal form and the bankruptcy chapter under which the debtor files. Chapter 9 generally preserves the strongest avenues for resident input through politically accountable officials. Nonprofit chapter 11 cases retain some protection for resident input through charitable-asset oversight and mission-based obligations. Finally, for-profit chapter 11 cases provide the weakest structural protections for resident input in the proceedings. Thus,

* B. Summer Chandler is the Cynthia Felder Fayard Professor of Law and a Professor of Professional Ethics and Associate Professor of Law at the Paul M. Hebert Law Center, Louisiana State University.

I am both honored and saddened to contribute to this special issue of the American Bankruptcy Law Journal to mark the passing of Professor Juliet M. Moringiello. Juliet was a prolific and versatile scholar whose work ranged widely and influenced many, but her impact extended well beyond her scholarship. She was also a generous mentor and a thoughtful colleague. I recall seeking her advice as I transitioned into academia after many years in practice. Although she offered practical guidance on advancing in my newly chosen career, what touched me most was that her advice began with the human side of academic life, cautioning me to recognize how isolating the work can be if we let it and to take care not to let it become that way.

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privatization of hospitals weakens traditional avenues for public participation by shifting control over essential health care infrastructure away from politically accountable actors. The problem is only compounded by efforts to consolidate health care services.

The article concludes that state and local leaders should act before bankruptcy occurs by carefully considering whether, and under what terms, to privatize public hospitals, monitoring hospital finances, strengthening oversight of hospital transactions, and creating mechanisms for resident participation, particularly in times of financial distress. When a hospital does enter bankruptcy, state and local officials and bankruptcy courts, acting within their respective authority and guided by applicable state law, should identify and give meaningful weight to the voice of the affected community when making decisions that may affect access to care.

Introduction

Hospital bankruptcies are not merely private disputes between distressed debtors and their creditors. Financial distress may threaten access to essential health care services in the communities they serve. Accordingly, these cases implicate not only creditor recovery and debtor rehabilitation but also state regulatory authority over public health and residents' ability to participate in decisions about critical community health care assets. Because hospital bankruptcies involve the restructuring of institutions that provide essential public health services, they raise governance concerns similar to those at the center of municipal bankruptcy, where insolvency affects public assets and the continued provision of public services to residents, even when the hospital is a private, for-profit entity. These bankruptcies also provide an important setting for examining how governmental choices made before financial distress arises may shape residents' ability to influence decisions about critical services once bankruptcy occurs.

Professor Juliet Moringiello's scholarship on municipal bankruptcy provides two insights that this article extends to the hospital bankruptcy context. First, she presents municipal bankruptcy as part of a state-federal partnership in which state choices shape how, and whether, federal bankruptcy law assists in resolving municipal financial distress. Second, she demonstrates that those state choices can have important consequences for democratic governance in bankruptcy. She highlights that because the authority to govern is reserved to the states under the Tenth Amendment, state involvement in resolving municipal distress, enabled by the constitutionally mandated

collaborative design of chapter 9 of title 11 of the United States Code,[1] is necessary and, in fact, often desirable. However, depending on how that intervention is structured, it may also displace local democratic participation and produce what Professor Moringiello describes as a "collective dispossession" of resident voice in decisions about important community assets.[2] More specifically, this concern about democratic governance arises when a state responds to municipal distress by ousting local elected officials and vesting control in a state-appointed receiver, emergency manager, or similar crisis decision-maker. Importantly, the process of displacing local democratic governance may have been set into motion by state choices made long before the municipality encounters financial distress.

This article considers these insights in the context of hospital bankruptcy.[3] Although Professor Moringiello's critique focuses on the loss of resident voice in chapter 9 cases in which state-appointed decision-makers displace local elected officials, this article broadens the inquiry to examine how state and local choices about the ownership and provision of hospital services may affect residents' ability to have their voices heard when a hospital later encounters financial distress. This article also considers how the bankruptcy chapter under which the hospital proceeds structures the avenues through which those interests may be heard, whether through state or local representatives, or directly by the residents themselves.

Like municipal entities, hospitals, regardless of their form of governance, provide services critical to the public's health, safety, and welfare. States bear primary responsibility for protecting those interests and, in carrying out that responsibility, regulate hospitals and health care markets and may delegate authority to local governments. As such, decisions regarding hospital ownership, governance, and continued operations implicate state police powers and state and local health care policy. Accordingly, hospital bankruptcies

[1] Title 11 shall be referred to in this article as the "Bankruptcy Code."

[2] Juliet M. Moringiello, *Dispossessing Resident Voice: Municipal Receiverships and the Public Trust*, 53 U. MICH. J.L. REFORM 733, 735 (2020) [hereinafter Moringiello, *Dispossessing Resident Voice*].

[3] For simplicity, this article will use the term "hospital bankruptcy" to refer both to the bankruptcy of a single hospital operating entity or the bankruptcy of a centralized health care system. These systems may consist of one or more acute care hospitals operating under centralized administration, together with other health care facilities, such as outpatient clinics, rehabilitation facilities, and urgent care centers.

Although this article focuses on acute care hospitals and health care systems that include such hospitals, similar issues regarding access to and quality of care can arise in proceedings involving nursing homes, psychiatric hospitals, and other long-term care or behavioral health providers.

require attention not only to federal bankruptcy law, but also to the state and local governance structures through which access to care is regulated, preserved, or altered.

When states choose to create public hospitals or delegate that authority to local municipalities, residents retain a political relationship with the governmental actors responsible for providing those services and may make their voices heard through voting or by expressing their views to elected representatives. When governmental actors instead rely on private entities to provide hospital services, that choice may reduce residents' opportunities to influence decisions about those services, a fact that may be particularly significant if the hospital later encounters financial distress. Thus, choices about hospital ownership and governance may shape the channels available for resident input long before bankruptcy occurs.

Once a bankruptcy case is filed, the degree to which resident voice is protected, and the means through which it may be heard, depend on both the debtor's legal form (public, private nonprofit, or private for-profit) and the chapter under which the case proceeds. When a public hospital proceeds under chapter 9, the Bankruptcy Code generally preserves governmental authority, providing the strongest structural protection for resident voice through elected officials, with state law determining whether that authority rests principally at the state or local level. Private, nonprofit chapter 11 cases may retain some protection of resident interests through state charitable-asset oversight and obligations tied to the hospital's nonprofit mission. Private, for-profit chapter 11 cases pose the greatest risk to resident input because decisions about hospital operations may shift away from elected or otherwise politically accountable officials and toward private actors and private interests. Importantly, in addition to having democratic value, community input may also have practical value. Studies suggest that community participation in healthcare planning can reveal local service gaps and transportation constraints that centralized decision-makers may overlook.[4] Further, community engagement may strengthen public trust, particularly when closures or service reductions are proposed.[5]

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[4] Jude Kornelsen *et al*., *Optimizing Community Participation in Healthcare Planning, Decision Making and Delivery Through Rural Health Councils*, 18 HEALTHCARE POL'Y 27, 36–37 (2022) (explaining that community participation can identify service gaps not understood outside the local community, improve decision making, and enhance public trust, particularly when closure or service reductions are threatened).

[5] Tabia Henry Akintobi *et al*., *Harnessing the Power of Community Engagement for Population Health*, 22 PREVENTING CHRONIC DISEASE E25, at 1–3 (2025), https://doi.org/10.5888/pcd22.250189 (discussing the value of community knowledge in identifying local priorities and linking meaningful engagement to strengthened partnerships,

This article argues that, because the protection and expression of resident voice in hospital bankruptcy depend in some respects on both the hospital's legal form and the bankruptcy chapter under which the case proceeds, those differences and their impact should be considered by decisionmakers both ex ante and ex post. Ex ante, state and local leaders should account for those differences when making decisions about hospital ownership, governance, and oversight. Ex post, those differences should be treated as a central concern during a hospital bankruptcy. Whether the hospital is public, private nonprofit, or private for-profit, state and local officials and bankruptcy courts, acting within their respective authority and guided by applicable state law, should identify and give meaningful weight to the voice of the affected community, while also considering the interests of future residents, when making decisions that may affect access to care, whether that voice is expressed through state officials, local officials, or other mechanisms for community participation.

This article proceeds as follows. Part I provides a brief overview of chapter 9 bankruptcy as compared to chapter 11 bankruptcy. It then presents Professor Moringiello's description of chapter 9 as a federal framework that preserves a significant role for state choice, including choices about how municipal governance and oversight occur during financial distress. Those choices, in turn, may shape residents' ability to participate in decisions concerning the disposition of public assets and the provision of essential services.

Part II provides further context for the article's examination of hospital bankruptcies by presenting the scale of health care expenditures within the U.S. economy and the economic consequences that may result from a lack of access to critical health care services. It also explains the allocation of authority between state and local governments. Part III discusses the ever-expanding privatization and consolidation of hospitals and other health care services. It also considers how those developments may alter governmental and community influence over hospital decision-making, while in some instances contributing to financial instability.

Part IV examines a collection of hospital bankruptcy cases, some of which were filed under chapter 9 and others under chapter 11. It considers how choices made before bankruptcy affect the role of state and local officials and the extent to which residents may be heard, directly or through politically accountable state or local representatives, once bankruptcy begins. Part V proposes reforms aimed at preserving and amplifying resident voice, both before and during bankruptcy. These reforms include careful consideration of

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improved health, and greater trust).

the risks associated with privatization, stronger financial monitoring, and regulatory intervention to avert bankruptcy where possible. It also advocates active participation by state and local governments in bankruptcy cases, particularly in for-profit chapter 11 cases, where public-interest protections are weakest.

I. Collaborative Bankruptcy and the Loss of Resident Voice

As detailed below, Professor Moringiello frames municipal bankruptcy as an intergovernmental enterprise whose success may depend, in part, on the degree of coordination among state and local officials and the federal bankruptcy court. Rather than treating chapter 9 as a self-contained federal remedy, she presents it as part of a broader system in which state choices play a central role in shaping outcomes. However, she also highlights that while state intervention may be necessary, the choices states make in implementing oversight and control may displace local democratic representation and impede residents' ability to have a voice in decisions about addressing the municipality's distress.

Similarly, this article examines how resident voice may be affected by state or local actors' decisions about whether and on what terms to privatize a community hospital, choices that may displace politically accountable decision-makers with private actors and thereby alter the avenues for resident voice if the hospital later enters bankruptcy. This Part will first provide a brief overview of chapter 9 bankruptcy as compared to chapter 11 bankruptcy. It will then turn to a brief summary of Professor Moringiello's scholarship on municipal distress, highlighting key insights that can be extended to hospital bankruptcies generally, where questions of governance and political accountability are likewise central.

A. A Tale of Two Chapters

Each year, thousands of businesses in the United States seek bankruptcy protection.[6] A hospital in the United States that is not a municipality typically files a "reorganization" case under chapter 11 of the Bankruptcy Code.[7] Or, if

[6] For example, in 2025, there were 24,737 bankruptcy filings in the United States with business debt as the predominant nature of the debt. ADMIN. OFF. OF THE U.S. COURTS, U.S. BANKR. CTS. BUS. AND NONBUS. CASES COMMENCED, BY CHAPTER OF THE BANKR. CODE, DURING THE 12-MONTH PERIOD ENDING DECEMBER 31, 2025, https://www.uscourts.gov/data-news/data-tables/2025/12/31/bankruptcy-filings/f-2.

[7] A hospital that is not a municipality could also file under chapter 7 of the Bankruptcy

the hospital is a "municipality" and otherwise eligible, the hospital might file under chapter 9 of the Bankruptcy Code. There were only three (3) chapter 9 bankruptcy filings in all of 2025, one of which was a hospital filing.[8] There were forty-five chapter 11 health care bankruptcy filings in 2025 with liabilities exceeding $10 million, a decline from fifty-seven such cases in 2024.[9] Although health care filings decreased overall in 2025, hospital cases with liabilities of $10 million or more increased 60% (from five to eight filings).[10] Financial distress in health care is expected to increase over the next several years, as The One Big Beautiful Bill Act (H.R. 1), signed into law in July of 2025, is expected to cut close to $1 trillion in funding to hospitals and other health care providers.[11]

Chapter 9 bankruptcy is like chapter 11 bankruptcy in that it provides a process for adjusting the debtor's debts. With respect to chapter 11, the Supreme Court has observed that "Chapter 11 strikes a balance between a debtor's interest in reorganizing and restructuring its debts and the creditors' interest in maximizing the value of the bankruptcy estate."[12] Unlike chapter 11

Code, known as liquidation bankruptcy. Relatively large, complex organizations, however, tend to choose chapter 11 over chapter 7, even if the ultimate goal is liquidation.

[8] The City of Cle Elum, Washington, filed for chapter 9 bankruptcy on June 24, 2025 (No. 25-01128) in the U.S. Bankruptcy Court for the Eastern District of Washington; the Palo Verde Healthcare District filed for chapter 9 bankruptcy on September 30 in the United States Bankruptcy Court for the Central District of California; and the Diablo Grande Community Facilities District No. 1 filed for chapter 9 bankruptcy on November 25, 2025 (Case 25-26635) in the Eastern District of California.

[9] GIBBINS ADVISORS, HEALTHCARE RESTRUCTURING: TRENDS AND OUTLOOK: ANALYSIS OF CHAPTER 11 HEALTHCARE BANKRUPTCIES SINCE 2019, FULL YEAR 2025 REPORT 5 (2026), https://static1.squarespace.com/static/6806e9bb1a73e928f078432d/t/69717ca58e3a9966a0331f20/1769045157489/Gibbins+Advisors+Healthcare+Bankruptcy+Full+Year+2025+Report+%281.22.26%29.pdf.

[10] *Id*. at 4. Senior care cases also increased 18% (from 11 to 13 filings). *Id*.

[11] Julia Burleson, *et al*., *Federal Budget Cuts Won't Hit All Hospitals Equally: How States Can Better Analyze Hospital and Health System Financial Data*, Health Affs. Forefront (Dec. 3, 2025), https://doi.org/10.1377/forefront.20251201.431222.

[12] Fla. Dep't of Revenue v. Piccadilly Cafeterias, Inc., 554 U.S. 33, 51 (2008). The legislative history of chapter 11 provides that its purpose "is to restructure a business's finances so that it may continue to operate, provide its employees with jobs, pay its creditors, and produce a return for its stockholders." *In re* Cedar Shore Resort, Inc., 235 F.3d 375, 379 (8th Cir. 2000) (*quoting* H.R. Rep. No. 595 (1975), reprinted in 1978 U.S.C.C.A.N. 6179).

A chapter 11 case, however, may involve the sale of some, or all, of the assets of the debtor pursuant to § 363 of the Code or pursuant to a plan of reorganization. In these instances, the chapter 11 filing may be focused on liquidating the debtor business as an operating business or liquidating the debtor entity's assets. Piccadilly Cafeterias, Inc., 554 U.S. at 37 ("Although the central purpose of chapter 11 is to facilitate reorganizations rather than liquidations (covered

bankruptcy, chapter 9 "is not concerned with balancing the rights of creditors and debtors. Rather, the principal purpose of chapter 9 is to allow municipal debtors the opportunity to continue operations while adjusting or refinancing their creditor obligations."[13]

Anyone who is permitted to be a debtor under chapter 7 "liquidation" bankruptcy is eligible to be a debtor under chapter 11.[14] Any "person" is eligible to file under chapter 7.[15] The Bankruptcy Code defines a "person" as including an "individual, partnership, and corporation," but it expressly does not include a "governmental unit."[16] The definition of "governmental unit" includes a "municipality."[17] As such, a municipality is not eligible for chapter 11.

Only a "municipality" may file for relief under chapter 9.[18] Professor Moringiello and other scholars have observed that chapter 9 has "strict eligibility requirements."[19] In addition to meeting the definition of "municipality," the municipality must also meet four additional eligibility requirements, including that the municipality must be specifically authorized to be a chapter 9 debtor under state law.[20]

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generally by chapter 7), chapter 11 expressly contemplates liquidations."). As discussed below, if the debtor in a chapter 11 wants to sell assets outside of the ordinary course of business, the debtor must obtain permission from the bankruptcy court.

[13] *In re* New York City Off-Track Betting Corp., No. 09-17121 MG, 2011 WL 309594, at *5 (Bankr. S.D.N.Y. Jan. 25, 2011) (*citing* H.R. Rep. No. 95-595, at 263 (1977), reprinted in 1978 U.S.C.C.A.N. 5787, 6221); *In re* Fin. Oversight & Mgmt. Bd. for Puerto Rico, 954 F.3d 1, 7–8 (1st Cir. 2020).

[14] 11 U.S.C. § 109(d).

[15] *Id*. § 109(b).

[16] *Id*. § 101(41).

[17] *Id*. § 101(27).

[18] 11 U.S.C. § 109(c). "Municipality" is defined in the Bankruptcy Code as a "political subdivision or public agency or instrumentality of a State." *Id*. § 101(40).

[19] Juliet M. Moringiello, *Specific Authorization to File Under Chapter 9: Lessons from Harrisburg*, 32 CAL. BANKR. J. 237, 244 (2012) ("Chapter 9 has strict eligibility requirements.") [hereinafter Moringiello, *Lessons from Harrisburg*]; Melissa B. Jacoby, *The Detroit Bankruptcy, Pre-Eligibility*, 41 FORDHAM URB. L.J. 849, 851 (2014) (observing that "[t]he Chapter 9 eligibility requirement for municipalities is not merely a pro forma hurdle"); Laura N. Coordes, *Bankruptcy and the Public-Private Divide*, 43 YALE L. & POL'Y REV. 418, 428 (2025) ("Chapter 9 . . . has the strictest eligibility requirements in the Bankruptcy Code.") [hereinafter Coordes, *Public-Private Divide*].

Some have argued that the chapter 9 eligibility standards are too onerous. *See*, *e.g*., Laura N. Coordes, *Gatekeepers Gone Wrong: Reforming the Chapter 9 Eligibility Rules*, 94 WASH. U. L. REV. 1191, 1195–96, 1241–44 (2017).

[20] In addition, to take advantage of chapter 9, the municipality must (1) be insolvent; (2) desire to effect a plan to adjust its debts; and (3) have made an effort to negotiate in good faith with its creditors before filing or show good reason not to have done so. *Id.* § 109(c).

This state-authorization requirement is itself a form of representative resident voice, albeit at the state level rather than the local one.[21] When elected state officials decline to authorize state municipalities to seek relief in bankruptcy, they make a choice on behalf of the state's residents to address municipal distress without resorting to the federal bankruptcy system. However, in practice, determining whether an entity should be classified as a municipality and, thus, eligible for bankruptcy only under chapter 9, if at all, is not always a simple task when considering entities that may exhibit attributes of a municipality, while also exhibiting attributes of a traditional business.[22]

Professor Laura Coordes identifies entities, such as special-purpose districts, government-created businesses, and nonprofits, as so-called "blended entities," observing that they are "bankruptcy misfits" because they do not fit neatly into either the chapter 9 or the chapter 11 box.[23] Because these entities fall into a gray area between the two, these entities may not be permitted to seek bankruptcy relief at all if they are treated as municipalities and are not authorized under state law to petition for bankruptcy protection.[24] Alternatively, these entities may obtain relief under chapter 11 that is constitutionally suspect, potentially undermining a choice made by state elected officials to deny bankruptcy as an avenue of debt relief to such entities.[25]

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[21] *In re* Trusty, 189 B.R. 977, 981 (Bankr. N.D. Ala. 1995) ("A [state] legislature is the voice of its electorate.").

[22] Coordes, *Public-Private Divide*, *supra* note 19, at 434 ("A significant and growing group of entities does not fit neatly into categories, however. These entities blend governmental (or public) and nongovernmental (or private) features, making it difficult to classify them as either 'municipalities' or nonmunicipal businesses for bankruptcy purposes."); *see also* Matthew A. Bruckner, *Special Purpose Municipal Entities and Bankruptcy: The Case of Public Colleges*, 36 EMORY BANKR. DEV. J. 341, *passim* (2020) (reviewing decisions addressing eligibility for relief under chapter 9 to extract a set of definitions for "municipality" for use in determining whether an entity should be categorized as a "municipality" for chapter eligibility purposes) [hereinafter Bruckner, *The Case of Public Colleges*].

[23] Coordes, *Public-Private Divide*, *supra* note 19, at 434.

[24] *In re* Hosp. Auth. of Charlton Cnty., No. 12-50305, 2012 WL 2905796, at *9 (Bankr. S.D. Ga. July 3, 2012) ("The reality is that not every entity is entitled to relief from its debts through bankruptcy. Some entities, like the Hospital Authority, may not be eligible for chapter 9 or chapter 11 relief."); *see also* Bruckner, *The Case of Public Colleges*, *supra* note 22, at 354–68 (analyzing the classification problem for public colleges and concluding that they are likely to be classified as municipalities for bankruptcy purposes and eligible for bankruptcy relief only under chapter 9, if bankruptcy relief is available at all).

[25] Coordes, *Public-Private Divide*, *supra* note 19, at 471 ("[M]any blended entities appear as if they belong in chapter 9 but are exploiting uncertainty about their features to file for chapter 11 and, sometimes, to receive relief only available in chapter 11.").

An entity with traditional governmental attributes or functions likely qualifies as a political subdivision or a state agency. *In re* Las Vegas Monorail Co., 429 B.R. 770, 788–89

While there are certainly similarities between chapter 9 bankruptcy and chapter 11 bankruptcy, there are important distinctions, many of which are anchored in federalism concerns.[26] As Professor Moringiello observed, the design of chapter 9 can be described as skeletal.[27] This skeletal design stems from the principle of dual sovereignty, grounded in the Tenth Amendment.[28] Chapter 9 selectively imports only certain specified chapter 11 provisions.[29]

Additionally, §§ 903 and 904 of the Bankruptcy Code recognize the court's limited power over operations of the debtor. Absent the consent of the debtor-municipality or as provided in the debtor's plan of adjustment, § 904 limits the power of the bankruptcy court to "interfere with—(1) any of the political or governmental powers of the debtor; (2) any of the property or revenues of the debtor; or (3) the debtor's use or enjoyment of any income-producing property."[30] Similarly, § 903 provides that chapter 9 "does not limit or impair the power of a State to control, by legislation or otherwise, a municipality of or in such State in the exercise of the political or governmental powers of the municipality, including expenditures for such exercise."[31] Given these limitations, unlike a chapter 11 case, there is no broad authority for a judge to appoint a trustee or an examiner in a chapter 9 case.[32]

(Bankr. D. Nev. 2010). If it does not, the question becomes whether it is an instrumentality, which turns on state control and public purpose. *Id*. The state must both assign a public function and retain meaningful control over its implementation, which is more than oversight or regulation. *Id.* Control designed to manage the state's finances or fisc supports instrumentality status. *Id.* Courts also give some weight, though not dispositive weight, to the state's classification of the entity, especially when that classification carries powers and functions characteristic of a municipality. *Id.*

[26] United States v. Bekins, 304 U.S. 27, 50–51, 58 (1938) (upholding the predecessor to chapter 9 as constitutional, because it was "carefully drawn so as not to impinge upon the sovereignty of the State. The State retains control of its fiscal affairs. The bankruptcy power is exercised in relation to a matter normally within its province and only in a case where the action of the taxing agency in carrying out a plan of composition approved by the bankruptcy court is authorized by state law.").

[27] *See infra* Part I.B.

[28] *In re* New York City Off-Track Betting Corp., 427 B.R. 256, 264 (Bankr. S.D.N.Y. 2010); H.R. Rep. No. 95-595, at 263 (1977), reprinted in 1978 U.S.C.C.A.N. 5963, 6221 ("[T]he powers of the court are subject to a strict limitation—that no order or decree may in any way interfere with the political or governmental powers of the petitioner, the property or revenue of the petitioner, or any income-producing powers.").

[29] 11 U.S.C. § 901(a).

[30] *Id.* § 904(a).

[31] *Id.* § 903.

[32] *Id.* § 901(a) (failing to incorporate §§ 1104, 1105, and 1106). A trustee may be appointed in a chapter 9 case for the limited purpose of bringing avoidance actions under §§ 544, 545, 547, 548, 549(a), or 550. *Id.* § 926(a).

In a chapter 11 case, the role of the judge is generally much more extensive. The debtor, acting through existing management, ordinarily continues to operate the business and manage the properties during the case as a debtor in possession.[33] However, the court may appoint a trustee or examiner for cause.[34] Additionally, the filing of a chapter 11 case results in the creation of a bankruptcy estate.[35] Sales of estate property outside the ordinary course of business require court approval.[36]

Unlike chapter 11, chapter 9 bankruptcy does not result in the creation of an estate.[37] Additionally, as noted, §§ 903 and 904 of the Bankruptcy Code recognize the court's limited power over operations of the debtor. The result is that the municipality does not need the bankruptcy court's approval for sales, expenditures, contracts, budgets, or operational decisions in the way a court may approve or police transactions involving estate property in a chapter 11 case.[38] Thus, in chapter 9, the absence of a bankruptcy estate, the debtor's exclusive authority to propose a plan, the prohibition on forced liquidation, and §§ 903 and 904 all serve to preserve state or municipal control over public hospitals in chapter 9.[39]

Despite significant differences, there are similarities between chapter 9 cases and chapter 11 cases. Chapter 9 cases and chapter 11 cases are similar in that in both cases the parties work towards the confirmation of a plan, called a plan of adjustment in chapter 9 and a plan of reorganization in chapter 11. Additionally, any "trustee, receiver or manager . . . including a debtor in

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[33] *Id.* §§ 1107(a), 1108.

[34] 11 U.S.C. § 1104(a), (c).

[35] *Id.* § 541.

[36] *Id.* §§ 363(b), 541(a). As discussed more fully below, in nonprofit chapter 11 cases, charitable-trust principles, as well as other principles and statutory provisions specific to nonprofit organizations, may constrain the disposition of assets. Whereas, in a for-profit chapter 11, neither public governance nor charitable-asset restrictions supply comparable restrictions.

[37] *Id*. § 901(a) (failing to incorporate § 541).

[38] *In re* New York City Off-Track Betting Corp., 427 B.R. 256, 264 (Bankr. S.D.N.Y. 2010) (The "fundamental constitutional principle" of dual sovereignty recognized by the Tenth Amendment "halts bankruptcy courts from regulating or otherwise controlling expenditures or activities of municipalities."); *see also* 5 WILLIAM J. NORTON, JR. & WILLIAM L. NORTON III, NORTON BANKRUPTCY LAW AND PRACTICE § 90:4 (3d ed. 2009) ("Without the consent of the municipality, the court may not interfere with any of the political or governmental powers of the debtor, any property or revenues of the debtor, or the debtor's use or enjoyment of any income-producing property.").

[39] It should be noted that chapter 9's limits on the bankruptcy court's ability to intervene in matters of governance have led some scholars to question its efficacy. *See, e.g.*, Vincent S.J. Buccola, *The Logic and Limits of Municipal Bankruptcy Law*, 86 U. CHI. L. REV. 817, 829–30 (2019).

possession, shall manage and operate the property in his possession . . . [in accordance with] the requirements of the valid laws of the State in which such property is situated, in the same manner that the owner or possessor thereof would be bound to do if in possession thereof."[40]

In both cases, the disclosure statement and the plan are subject to court approval, and the plan proponent solicits votes from creditors on whether to accept or reject the plan. Although other parties in interest may have an opportunity to file a proposed plan in a chapter 11, only the debtor may file a plan of adjustment in a chapter 9 bankruptcy.[41] The plan generally outlines how the debtor will restructure their finances, repay creditors, and continue operations. Alternatively, in a chapter 11 case, the plan may provide for the winding up of the debtor's business. Because a municipality cannot be forced to liquidate, and it exists to provide services to its citizens, liquidation in the traditional sense is not generally perceived as an option in chapter 9.[42]

Given the constitutional limitations on the role of the judge and other parties in a chapter 9 case, the debtor plays a central role in how the case proceeds and its ultimate outcome.[43] Still, the bankruptcy court retains authority over two critical decisions—whether the debtor is eligible to file under chapter 9, and whether to approve or deny the municipality's plan of adjustment. In addition, the court has the authority to dismiss a chapter 9 case "for cause," which includes "denial of confirmation of a plan under section 943(b) of this title and denial of additional time for filing another plan or a modification of a plan."[44]

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[40] 28 U.S.C. § 959. At least one court has found that this provision does not apply to the chapter 9 debtor. *In re* Jefferson Cnty., Ala., 484 B.R. 427, 458–62 (Bankr. N.D. Ala. 2012).

[41] 11 U.S.C. § 941.

[42] Diane Lourdes Dick, *Public Hospital Bankruptcies and an Evolving Functional Interpretation of the Bankruptcy Code*, BANKR. L. LETTER, Aug. 2019, at 1, 5.

[43] *See* FED. JUD. CTR., NAVIGATING CHAPTER 9 OF THE BANKRUPTCY CODE 34 (2017) (explaining that "[t]he debtor in a Chapter 9 case plays a pivotal role in the direction and outcome of the case. The prominence of the debtor stems, in part, from the constitutional limitations on the role of the judge and other parties in the case").

[44] Section 943(b) provides:

The court shall confirm the plan if—

(1) the plan complies with the provisions of this title made applicable by sections 103(e) and 901 of this title;

(2) the plan complies with the provisions of this chapter;

(3) all amounts to be paid by the debtor or by any person for services or expenses in the case or incident to the plan have been fully disclosed and are reasonable;

(4) the debtor is not prohibited by law from taking any action necessary to carry out the plan;

(5) except to the extent that the holder of a particular claim has agreed to a different

Confirmation of a chapter 9 plan is governed by § 943(b), which requires, among other things, that "any regulatory or electoral approval necessary under applicable nonbankruptcy law in order to carry out any provision of the plan has been obtained, or such provision is expressly conditioned on such approval," that it be feasible and that it be in the best interests of creditors.[45] Chapter 11 plans must also be feasible[46] and in the best interests of creditors.[47] Section 943(b) also incorporates certain of the requirements for the confirmation of a plan, including that the plan may not discriminate unfairly and must be fair and equitable with respect to dissenting creditor classes.[48]

B. Federalism, Property Rights, and Resident Voice in Municipal Bankruptcy

Professor Moringiello's municipal bankruptcy scholarship frames chapter 9 as a deliberately incomplete federal remedy whose success depends on coordination between federal bankruptcy law and state-law systems of municipal governance. Although some scholars have argued that chapter 9's skeletal design undermines its efficacy, Professor Moringiello treats that skeletal design as an invitation to the states to engage in a state-federal

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treatment of such claim, the plan provides that on the effective date of the plan each holder of a claim of a kind specified in section 507(a)(2) of this title will receive on account of such claim cash equal to the allowed amount of such claim;

(6) any regulatory or electoral approval necessary under applicable nonbankruptcy law in order to carry out any provision of the plan has been obtained, or such provision is expressly conditioned on such approval; and

(7) the plan is in the best interests of creditors and is feasible.

11 U.S.C. § 943(b).

[45] *Id*.

[46] *Id*. § 1129(a)(11); *see also In re* Chicago Invs., LLC, 470 B.R. 32, 107 (Bankr. D. Mass. 2012) (explaining that § 1129(a)(11) of the Bankruptcy Code "provides that a plan may only be confirmed if confirmation is not likely to be followed by liquidation, or the need for further financial reorganization. Commonly referred to as the feasibility requirement, the purpose of this test is to ensure that the plan is not a 'visionary scheme'") (internal quotation marks omitted).

[47] 11 U.S.C. § 1129(7); *see also In re* Capmark Fin. Grp. Inc., No. 09-13684 (CSS), 2011 WL 6013718, at *30 (Bankr. D. Del. Aug. 24, 2011) (explaining that section 1129(a)(7) "requires that a plan must be in the 'best interests' of creditors and interest holders. . . . Under the best interests test, the court must find that each creditor will receive or retain value that is not less than the amount he would receive if the debtor were liquidated") (internal citations omitted).

[48] 11 U.S.C. § 901(a) (incorporating § 1129(b)(1), (2)(A)–(B)).

partnership for alleviating municipal financial distress, resulting from constitutional constraints.[49]

Her early work on municipal bankruptcy considers the City of Harrisburg's failed attempt to obtain relief in chapter 9.[50] In this piece, she focuses on the gatekeeping function of state law contained in the Bankruptcy Code's chapter 9 eligibility requirements, which provide, among other things, that a municipality may not file under chapter 9 unless it is "specifically authorized" by the state.[51] In the Harrisburg case, the City sought relief in chapter 9 despite the fact that the Pennsylvania legislature had just recently passed legislation forbidding cities such as Harrisburg from filing.[52] The bankruptcy court promptly dismissed the filing, finding that the city was not specifically authorized by state law to be a debtor in chapter 9.[53] Using Harrisburg's attempted bankruptcy as a case study, she illustrates two significant limitations on using chapter 9 as a tool to resolve municipal financial distress, "first, a state has absolute discretion in allowing or prohibiting bankruptcy petitions by its municipalities, and second, although Chapter 9 can be a useful tool to deal with municipal debt, it plays no role in ameliorating a city's internal political strife."[54]

Professor Moringiello's municipal bankruptcy scholarship then turns to focus on the role that federal bankruptcy might play in resolving municipal distress.[55] She challenges the dominant scholarly assumption that federal bankruptcy and avenues for state intervention operate as alternatives to addressing financial distress, demonstrating instead that chapter 9 is best understood as one part of a deliberately integrated design.[56]

Drawing on the evolution of municipal bankruptcy law and its constitutional implications, she explains that, "[t]he Tenth Amendment limits the control that a federal court can exercise over a municipality, and the Contracts Clause limits the ability of a state to force a creditor of a city to accept less than what it is owed."[57] States can provide ongoing fiscal supervision and institutional reform, but cannot bind nonconsenting creditors, while the federal

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[49] *See generally* Juliet M. Moringiello, *Goals and Governance in Municipal Bankruptcy*, 71 WASH. & LEE L. REV. 403 (2014) [hereinafter Moringiello, *Goals and Governance*].

[50] Moringiello, *Lessons from Harrisburg*, *supra* note 19, *passim*.

[51] *Id.* at 244–45, 255–59.

[52] *Id.* at 250.

[53] *Id.*

[54] *Id.*

[55] Moringiello, *Goals and Governance*, *supra* note 49, *passim*.

[56] *Id.* at 411.

[57] *Id*.

law can impose a binding plan of adjustment, but "cannot provide the active fiscal guidance that was needed to ensure that a municipality could both resolve its current problems and avoid future problems."[58] It is this dual limitation that leads her to conclude that Congress enacted municipal bankruptcy law "to bring together two sovereigns, the state and the federal government, to accomplish something that neither could accomplish alone—the imposition of a plan to adjust municipal debts that would be binding on all creditors."[59] She explains that chapter 9 "was never designed to be an independent solution to municipal financial problems," but was instead designed "to complement, rather than replace, state financial intervention plans."[60]

Building on this framing of chapter 9 as complementary to state intervention, her scholarship next examines how that complementary design should inform bankruptcy courts' interpretation of chapter 9 plan confirmation standards.[61] Examining the bankruptcy cases of Detroit and Stockton, she illustrates that the chapter 11 understanding of concepts such as "best interests," "fair and equitable," and "unfair discrimination" cannot be wholesale imported into municipal bankruptcy because, among other things, municipal bankruptcy does not rest on the same foundations regarding capital structure, liquidation value, or residual ownership.[62]

For example, she observes that many assert that assets held by a municipality for public use are held in public trust and may not be seized by creditors.[63] She also observes that the "[m]unicipal bankruptcy law does not seek to distribute a municipality's monetary value to its creditors."[64] As such, she explains, the "best interests test," which, in a chapter 11 case would be satisfied if each dissenting creditor receives at least as much under the plan as it would if the debtor's assets were liquidated and distributed to creditors, cannot be neatly applied in chapter 9.[65] Further, if the municipal debtor chooses to sell a public asset, she explains, a court might consider "the purpose of the municipality and the needs of the residents in determining that the value received by the debtor was sufficient to satisfy the best interests test."[66]

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[58] *Id*. at 446–47.
[59] *Id*. at 408.
[60] *Id*. at 409.
[61] Juliet M. Moringiello, *Chapter 9 Plan Confirmation Standards and the Role of State Choices*, 37 CAMPBELL L. REV. 71, 75 (2015) [hereinafter Moringiello, *Confirmation Standards*].
[62] *Id*. at 78–84.
[63] *Id*. at 93–94.
[64] *Id*. at 79.
[65] *Id*. at 95.
[66] *Id*.

Given the foundational distinctions between chapter 9 and chapter 11, and the constitutional concerns that undergird chapter 9's design, Professor Moringiello argues that plan confirmation standards such as "best interests," "fair and equitable," and "unfair discrimination" should be interpreted and applied by reference to state choices regarding the resolution of financial distress.[67] However, again acknowledging the importance of the state-federal partnership, Professor Moringiello notes that the role of state choice in interpreting plan confirmation standards is less clear when a state does not choose to "fill the gaps" left by chapter 9.[68]

Professor Moringiello next shifts the focus of her scholarship to illustrating how state-law choices might be used to fill the gaps in chapter 9. She first notes the ubiquitous role of property rights in chapter 11 bankruptcy and its largely incongruent fit in chapter 9.[69] She explains that in chapter 11 bankruptcy, the bankruptcy estate and state-law property rights supply the baseline for distribution to creditors.[70] That well-understood baseline in chapter 11, however, is uncertain in chapter 9, because municipal property is generally understood to be held in "public trust" and unavailable to creditors in a forced liquidation.[71] She observes that municipal finance rests not on private-law property entitlements but on public-purpose borrowing, statutory and constitutional signals regarding priority, and promises about governmental performance.[72] As such, she contends, in determining priorities in chapter 9, bankruptcy courts should "incorporate state choices insofar as they govern how a municipality can borrow money" and consider things such as statutory signals about creditor expectations, the public purposes of municipal finance, and the municipality's continuing obligation to provide essential services.[73]

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[67] *Moringiello, Confirmation Standards*, *supra* note 61, *passim*.

[68] *Id*. at 105.

[69] Juliet M. Moringiello, *Decision-Making and the Shaky Property Foundations of Municipal Bankruptcy Law*, 12 BROOK. J. CORP. FIN. & COM. L. 5, 13–14 (2017) [hereinafter Moringiello, *Shaky Property Foundations*].

[70] *Id*. at 17–18, 20–21.

[71] *Id*. As discussed more fully below, somewhat analogous constraints can arise in nonprofit chapter 11 cases through charitable-trust principles, which may limit whether and to what extent certain assets held by the debtor nonprofit may be used to satisfy creditor claims. *See*, *e.g.*, *In re* HHH Choices Health Plan, LLC, 554 B.R. 697, 701–04 (Bankr. S.D.N.Y. 2016) (approving the sale of nonprofit health-care assets to the bidder that better promoted the debtor's charitable mission); *see also In re* Roman Cath. Archbishop of Portland in Oregon, 345 B.R. 686, 693 (Bankr. D. Or. 2006) (explaining that property held in a charitable trust is not property of the bankruptcy estate).

[72] Moringiello, *Shaky Property Foundations*, *supra* note 69, at 17–18, 20–21.

[73] *Id*. at 35–37.

After highlighting the importance of state-law choices in chapter 9, Professor Moringiello then turns her attention to the potential impact on resident voice.[74] Although she recognizes the critical importance of a state's engagement in the resolution of its municipality's distress in chapter 9, she also highlights the potential consequences for democratic governance at the local level. Because governance is left to state law, the state's chosen approach to municipal financial distress—ranging from leaving primary decision-making authority with local elected officials, to imposing more extensive oversight through fiscal control boards, emergency managers, or receiverships—establishes the site of decision-making authority during financial distress.[75]

She observes that while municipal property is held in "public trust" for residents, the state's appointment of unelected actors—such as a receiver, emergency manager, or other crisis manager—to resolve a financial crisis can strip residents of democratic agency. This type of intervention, she observes, may result in the "collective dispossession . . . of resident voice in local government affairs."[76] She explains that when unelected officials appointed by the state government assume control, they make important decisions, such as whether to monetize or transfer municipal assets the city holds for residents "in public trust," thereby potentially reshaping the community without participation by local elected officials or residents.[77] She notes that "it is unclear what the duties of elected officials are to the public when they monetize public property. It is even less clear what the duties of appointed receivers and emergency managers are."[78]

Professor Moringiello contends that by choosing to replace elected officials with unelected decisionmakers, "a state dispossesses citizens of their voice in choosing the people who determine the future of the property held for them in the public trust."[79] Importantly, Professor Moringiello's concern does not center on the fact of state-level appointments, *per se*. State elected officials appoint individuals to oversee and manage a myriad of issues and assets. The governor-appointed board of a public college, for example, may be part of an ordinary state-law governance structure and, in that sense, may reflect a mediated form of resident voice through elected state officials. Rather, her concern centers on the ousting of local elected officials and the replacement of them with state-appointed delegates in times of fiscal distress. When financial

[74] Moringiello, *Dispossessing Resident Voice*, *supra* note 2, at 736.
[75] *Id*.
[76] *Id*. at 735.
[77] *Id*. at 751.
[78] *Id.*
[79] *Id.*

distress triggers the override of ordinary local governance by a state-appointed receiver, emergency manager, or other crisis manager, decisions about public assets are made under pressure to stabilize finances, satisfy creditors, and balance budgets. Because a state's chosen oversight mechanism is respected at the federal level in chapter 9, the federal–state partnership in chapter 9 risks marginalizing the very constituencies most affected by municipal restructuring.[80]

Professor Moringiello emphasizes that "[t]he residents of a municipality are the ones who are going to have to live with the long-term consequences of any recovery plan," and therefore "[t]heir voice in the process should . . . be preserved."[81] She does not suggest that local representation is necessarily superior to state representation. Rather, Professor Moringiello recognizes that state intervention may sometimes be necessary[82] and proposes reforms that offer opportunities for resident input and advocates for states to implement a form of "cooperative oversight."[83]

A similar concern arises when state or local governments respond to fiscal pressures by privatizing hospital services. That choice may shift control of a critical community service away from politically accountable actors and, if the private hospital later files for bankruptcy, leave residents with fewer avenues to influence decisions that affect access to care. Because hospitals provide critical services much like other essential public institutions, state and local officials should consider how decisions about hospital ownership and governance may affect public control and resident voice, particularly if the hospital later encounters financial distress.

II. Health Care, the Economy, and the Police Power

Health care expenditures constitute a substantial share of the United States economy, and inadequate access to hospitals and other health care facilities can impose high economic and social costs on local communities. States retain primary authority over the provision, funding, and oversight of

[80] *Id*. Of course, the same displacement of local elected leaders can occur outside the context of bankruptcy when a state receivership or other state-managed intervention is imposed. *See*, *e.g*., Moringiello, *Lessons from Harrisburg, supra* note 19, *passim* (explaining that, after the bankruptcy petition filed for Harrisburg by its city council was dismissed as unauthorized by the Commonwealth, the Commonwealth Court approved appointment of a receiver whose plan could include the sale of city assets).

[81] Moringiello, *Dispossessing Resident Voice*, *supra* note 2, at 752.

[82] *Id.* at 747.

[83] *Id.* at 734, 752.

health care services, although they frequently delegate aspects of that authority to local governments, particularly with respect to public hospitals and other publicly operated health care institutions.

A. Hospitals as Critical Community Institutions

Hospitals occupy an important place in the communities they serve. The scale of health care spending provides one measure of the significance of the services at stake. The Centers for Medicare & Medicaid Services (CMS) tracks comprehensive estimates of total annual spending in the United States for health care services and related goods, referred to as National Health Expenditures (NHE). According to CMS, NHE reached $5.3 trillion in 2024, comprising 18% of gross domestic product (GDP).[84] Total hospital spending accounted for almost one-third (31.0%) of overall health spending in 2024.[85] Additionally, although much of the health care system is privately owned and operated, a substantial share of its revenues ultimately comes from public funds. Government-provided insurance programs, such as Medicare and Medicaid, accounted for 39% of total NHE in 2024.[86] Thus, privatization of a hospital does not necessarily mean a withdrawal of taxpayer-funded financial support from that facility.

Despite the scale of health care expenditures in the United States, hospitals themselves may be financially vulnerable. In fact, since the COVID-19 pandemic, financial sustainability has remained a central challenge for hospitals in the United States.[87] Examining certain financial, operational, and other data of all U.S. short-term acute care hospitals from 2021 to 2023, one study found that the proportion of hospitals classified as severely financially distressed increased from 18.6% in 2021 to 22.0% in 2023—more than one in five.[88] This study also found that rising debt and declining margins put more

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[84] CTRS. FOR MEDICARE & MEDICAID SERVS., *Nat'l Health Expenditure Data: NHE Fact Sheet* (Jan. 14, 2026) [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS., *Nat'l Health Expenditure Data*], https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

[85] Shameek Rakshit *et al*., *How Has U.S. Spending on Healthcare Changed Over Time?*, Peterson-KFF Health Sys. Tracker, (Jan. 22, 2026), https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/.

[86] CTRS. FOR MEDICARE & MEDICAID SERVS., *Nat'l Health Expenditure Data*, *supra* note 84.

[87] James R. Langabeer *et al*., *Determinants of Severe Financial Distress in U.S. Acute Care Hospitals: A National Longitudinal Study*, 14 HEALTHCARE 366, 2 (2026), https://doi.org/10.3390healthcare14030366.

[88] *Id*. at 5.

than 566 facilities at heightened risk of closure or bankruptcy.[89] This study observed that "[h]ospital financial distress at this scale signals a growing risk of service reductions and closures that could undermine regional health-care capacity and limit access in many communities."[90] These potential consequences are especially significant because residents may have little or no opportunity to influence decisions that directly affect their access to a critical service and, therefore, a fundamental aspect of community life.

Hospital closures may reduce the surrounding residents' access to health care.[91] The impact on access may be particularly stark for rural communities, where hospitals may be the only source of certain medical services.[92] One study showed that hospital closure especially affected access to emergency services.[93] Elderly and low-income residents were disproportionately affected by transportation barriers following the closures and were therefore more likely to delay or forgo needed medical treatment.[94] The closures also prompted an outflow of health care professionals and exacerbated existing shortages in specialty care, further eroding access to health care.[95] The closure of rural hospitals also often increases the travel time to the next closest service provider, leading to significantly worsened health outcomes and higher mortality risks for matters for which a delay in care can significantly impact the outcome, such as a stroke or heart attack.[96]

In addition to affecting the individuals who lack access to care in a very personal and profound way, hospital closures can also have substantial consequences for the surrounding community. Hospitals employ approximately 4.5 million workers in the United States and have been described by some as "economic anchors, if not engines for growth, within their surrounding

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[89] *Id*. at 1–2.

[90] *Id*. at 8.

[91] Jane Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Fam. Found. & Urban Inst., (July 7, 2016) [hereinafter Wishner, *Rural Hospital Closures*], https://www.kff.org/medicaid/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/.

[92] Christian Cox, Derek A. Epp & Michael E. Shepherd, *Access to Healthcare and Voting: The Case of Hospital Closures in Rural America*, 119 AM. POL. SCI. REV. 1233 (2025).

[93] Wishner, *Rural Hospital Closures*, *supra* note 91, at 7.

[94] *Id*. at 8.

[95] *Id*. at 7–8.

[96] Katherine E. M. Miller *et al*., *The Effect of Rural Hospital Closures on Emergency Medical Service Response and Transport Times*, 55 HEALTH SERVS. RES. 288 (2020); Kritee Gujral & Anirban Basu, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality* (Nat'l Bureau of Econ. Rsch., Working Paper No. 26182, rev. June 2020).

communities."[97] Studies show that hospital closures in rural areas lead to sharp losses in employment in the health care sector.[98]

These potential consequences help explain why decisions about the ownership, governance, continued operation, or closure of a hospital implicate interests extending beyond those of the hospital and its creditors. Because residents ultimately bear the consequences of diminished access to these critical services, the legal structures through which those services are provided, and the opportunities those structures afford residents to influence decisions affecting them, matter.

B. State Regulation of Hospitals Generally

The United States' health system is a complex network of public and private actors operating at the national, state, and local levels.[99] Under the Tenth Amendment of the United States Constitution, the powers not delegated to the federal government are reserved to the states or to the people.[100] Thus, a general police power is retained by the states.[101] This police power includes the authority to protect public health and safety.[102] "Numerous Supreme Court decisions have identified the regulation of health matters as a core facet of a state's police powers."[103] The Supreme Court has recognized this authority as broad, observing that "[b]ecause these are 'primarily, and historically, . . . matter[s] of local concern,' the 'States traditionally have had great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.'"[104]

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[97] Diane Alexander & Michael R. Richards, *Economic Consequences of Hospital Closures*, 221 J. PUB. ECON. 104821 (2023).

[98] *Id*. at 2.

[99] Justeen K. Hyde & Stephen M. Shortell, *The Structure and Organization of Local and State Public Health Agencies in the U.S.: A Systematic Review*, 42 AM. J. PREVENTIVE MED. 1 (2012).

[100] U.S. Const. amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.").

[101] *In re* Subpoena No. 25-1431-014, 810 F.Supp.3d 555, 563 (2025).

[102] *See* Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996) ("Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens."); Slaughter–House Cases, 83 U.S. 36, 62 (1872); *In re* Subpoena No. 25-1431-014, 810 F.Supp.3d 555 (2025).

[103] ETP Rio Rancho Park, LLC v. Grisham, 522 F. Supp. 3d 966, 1038 (D.N.M. 2021) (internal quotations omitted) (collecting Supreme Court cases).

[104] Medtronic, Inc. v. Lohr, 518 U.S. at 475 (internal citations and quotations omitted).

To the extent local municipalities hold authority to own or operate public hospitals, they derive that authority from the state in which they are located.[105] Given the flexibility states have in structuring their oversight and regulation of public health, the governmental approaches across the states vary to some degree.[106] States, however, generally permit counties and municipalities to own and operate hospitals or create a separate hospital district or other instrumentality to do so.[107] Public hospitals are typically structured as hospital districts, a form of local government created by the county or city government.[108]

States regulate all hospitals pursuant to their police power to protect public health, welfare, and safety.[109] Courts have found that, regardless of whether a hospital is publicly or privately owned, it is operated for the promotion and protection of public health and, as such, is subject to state regulation.[110] Most states exercise their powers to regulate hospitals through certificate-of-need, licensure, and other requirements that govern hospitals' ongoing operations and are typically aimed at regulating health and safety.[111]

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[105] Because the Constitution is silent as to the distribution of power between state governments and their municipalities, courts and commentators have taken that silence to mean whether local municipalities exist and, if they do exist, the scope of their powers is left to the states. *See*, *e.g.*, Gerald E. Frug, *The City as a Legal Concept*, 93 HARV. L. REV. 1059, 1062 (1980); *see also* Boise Artesian Hot & Cold Water Co. v. Boise City, 230 U.S. 84, 94 (1913) ("[M]unicipalities are mere emanations from the state, exercising such public power as the state chooses to grant.").

[106] Public Health Law Center, *State & Local Public Health: An Overview of Regulatory Authority*, https://www.publichealthlawcenter.org/resources/state-local-public-health-overview-regulatory-authority.

[107] *See, e.g.*, Ala. Code § 22-21-71 (2025) (expressly authorizing counties to form public corporations for the purpose of acquiring, owning, and operating public hospitals and other public health facilities).

[108] Nancy M. Kane *et al.*, *Strained Local and State Government Finances Among Current Realities that Threaten Public Hospitals' Profitability*, 31 HEALTH AFFS. 1680, 1680 (2012).

[109] York Hosp. v. Maine Health Care Fin. Comm'n, 719 F. Supp. 1111, 1122 (D. Me. 1989) ("State or local control of health and safety matters are presumptively valid exercises of state police power.").

[110] Foster v. N. Carolina Med. Care Comm'n, 195 S.E.2d 517, 528 (N.C. 1973) ("It is elementary that the promotion and protection of the public health is a proper subject for exercise of the police power of the State and, obviously, hospitals, whether publicly or privately owned, are operated for that purpose and subject to State regulation.").

[111] Alexandra D. Montague *et al.*, *Considerations for State-Imposed Conditions on Healthcare Provider Transactions*, FRONT. PUB. HEALTH, Aug. 16, 2023, at 1, 3–4 [hereinafter Montague, *Considerations*].

Some states impose various financial reporting requirements.[112] However, seventeen states impose no financial reporting requirements.[113] The Maine Uniform Reporting System,[114] administered by the Maine Health Data Organization (MHDO),[115] is an example of a robust financial oversight system. The system requires a broad array of health care providers and their parent entities to file comprehensive, audited financial information at least annually. The parent entity must submit audited consolidated financial statements that include balance sheets, income statements, statements of changes in net assets, and cash flow statements for the entire corporate structure.[116] In addition, each individual hospital or other facility within the corporate structure must submit its own separate audited financial statements and other detailed supplemental information.[117] Finally, both the parent entity and each hospital must complete and submit the MHDO Standardized Accounting Template. Standardization is important because it permits the MHDO and other reviewers to compare financial metrics across providers.[118] The MHDO processes this data, publishes aggregated, de-identified reports for public access on its website, and shares specific reports with state-level government.[119]

Many states regulate hospitals through some form of certificate-of-need requirement[120] or other transaction oversight requirements.[121] Although there are variations among the states, certificate-of-need regulations generally require health care providers to obtain state approval before offering new services, expanding existing services, purchasing major equipment, or making significant capital expenditures.[122] To obtain this approval, the health care

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[112] *See* CTR. ON HEALTH INS. REFORMS, *Hospital Financial Reporting Requirements*, GEORGETOWN UNIV. MCCOURT SCH. OF PUB. POL'Y, https://chir.georgetown.edu/state-oversight-of-hospitals/hospital-financial-reporting-requirements/.

[113] *Id*.

[114] Me. Rev. Stat. Ann. tit. 22, §§ 8701–8741 (2025).

[115] *Id.* § 8703.

[116] Me. A.D.C. 90–590 Ch. 300, § 2 (2025).

[117] *Id*.

[118] *Id*.

[119] Me. Rev. Stat. Ann. tit. 22, § 8704.

[120] NAT'L CONF. OF STATE LEGISLATURES, *Certificate of Need State Laws* (updated Apr. 29, 2025) [hereinafter NAT'L CONF. OF STATE LEGISLATURES, *Certificate of Need State Laws*], https://www.ncsl.org/health/certificate-of-need-state-laws.

[121] The Center on Health Insurance Reform provides an extensive collection of the various statutory and regulatory mechanisms states employ in their oversight and regulation of hospitals and hospital transactions. *See* CTR. ON HEALTH INS. REFORMS, *State Oversight of Hospitals*, GEORGETOWN UNIV. MCCOURT SCH. OF PUB. POL'Y, https://chir.georgetown.edu/state-oversight-of-hospitals/.

[122] NAT'L CONF. OF STATE LEGISLATURES, *Certificate of Need State Laws*, *supra* note 120;

provider must demonstrate that the planned new, altered, or expanded services are needed.[123] The laws are designed to prohibit providers from offering expensive, unnecessary services, thereby saving patients and other payors from those costs.[124] They are also designed to improve health care access by preventing duplicative services in a given area, thereby encouraging providers to serve underserved rural or low-income areas.[125]

Hospitals are also subject to state licensing requirements. In addition to obtaining a certificate of need, the health care provider must obtain a license to operate in the state.[126] An applicant generally must demonstrate competence and that it can meet certain specified minimum standards of conduct and performance.[127] After a license is issued, the state regulatory agency may later revoke it for serious misconduct, such as serious or repeated violations of safety codes or other actions that materially affect patient safety.[128] Hospitals are also

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see also Matthew D. Mitchell, *Certificate of Need Laws in Health Care: Past, Present, and Future*, INQUIRY: J. HEALTH CARE ORG., PROVISION & FIN., Jan.–Dec. 2024, at 1 [hereinafter Mitchell, *Certificate-of-Need Laws*], https://pmc.ncbi.nlm.nih.gov/articles/PMC11088301/pdf/10.1177_00469580241251937.pdf.

[123] NAT'L CONF. OF STATE LEGISLATURES, *Certificate of Need State Laws*, *supra* note 120.

[124] Mitchell, *Certificate-of-Need Laws, supra* note 122, at 1–2.

[125] Christopher J. Conover & James Bailey, *Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis*, 20 BMC HEALTH SERVS. RSCH. 748, 1 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7427974/pdf/12913_2020_Article_5563.pdf.

Some researchers have questioned whether these regulations actually serve their intended purpose, and studies have shown they may negatively affect access to services. *Id.* While most states still have certificate-of-need laws, some have moved to repeal them. NAT'L CONF. OF STATE LEGISLATURES, *Certificate of Need State Laws*, *supra* note 120.

[126] Honorable Brian P. Stern & Christopher J. Fragomeni, *The Triage and Treatment of Healthcare Institutions in Distress: How to Involve State Regulators in Healthcare Bankruptcies and Receiverships*, 22 ROGER WILLIAMS U. L. REV. 147, 158 (2017) (collecting applicable statutes) [hereinafter Stern, *Triage and Treatment*]; *see also* 40A Am. Jur. 2d Hospitals and Asylums § 5 ("The operation of an institution for the shelter, feeding, and care of sick, aged, or infirm persons bears a reasonable relation to the health, safety, and welfare of the community, and is thus subject to licensing and regulation by the state as a valid exercise of the police power.").

[127] *See*, *e.g.*, Noel v. Lawrence & Mem'l Hosp., 53 Conn. Supp. 269, 271 (Super. Ct. 2014) ("Under General Statutes § 19a–13 a license is, by definition, only for hospitals that can 'demonstrate competence' and prove following examination that they meet 'minimum standards.'").

[128] Forgione v. HCA Inc., 954 F. Supp. 2d 1349, 1357 (N.D. Fla. 2013) ("The hospital's license could be revoked by AHCA if the agency found an intentional or negligent act materially affecting the health or safety of a client of the provider or a demonstrated pattern of deficient performance.").

subject to ongoing regulations pertaining to matters such as insurance, fire and safety, and sanitation.[129]

A hospital's certificate of need and license are generally not transferable. As such, any purchaser must apply for and obtain its own approval to operate the facility.[130] In addition, some states impose state approval requirements for certain changes in ownership. Sometimes called "conversion laws," these laws govern when and how a hospital may change its ownership structure, convert from one organizational form to another, or transfer material assets or operational control to another entity.[131] Because nonprofit hospital assets are treated as assets held in a charitable trust for the public benefit, these laws have traditionally applied primarily to nonprofit hospitals seeking to transfer assets or control to a for-profit buyer.[132] Most states have some form of conversion law, whether enacted by statute or charitable trust doctrine.[133] These obligations operate in addition to certain federal requirements, such as antitrust pre-merger notifications,[134] Medicare change-of-ownership rules,[135] and federal tax-exempt status obligations.[136]

In recent years, as the privatization of hospitals and the consolidation of health care services have rapidly expanded, "[s]tate officials are developing and pursuing policy initiatives aimed at health market oversight as a way to increase affordability, while ensuring access."[137] As a result, some states have enacted more robust oversight and control systems for health care transactions. In fact, some states have enacted systems that give the state broad authority to review a wide range of transactions that would result in the transfer of ownership or

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[129] *See, e.g.*, *id*. ("[L]icensed hospitals are subject to department of public health regulations concerned with 'promoting safe, humane and adequate care and treatment of individuals in institutions.'"); Okla. Admin. Code § 310:667-5-3 ("The hospital shall be in conformity with federal, state, and local laws relating to fire and safety, to communicable and reportable diseases, to occupational safety and health, and to other relevant matters.").

[130] Stern, *Triage and Treatment, supra* note 126, at 186–87.

[131] Montague, *Considerations*, *supra* note 111, at 3.

[132] *See*, *e.g.*, Colo. Rev. Stat. Ann. § 6-19-101 (2025) ("The public . . . has an interest in knowing that the transfer of the assets of a nonprofit hospital, or the proceeds from the assets, preserves, to the extent practicable, their charitable purpose.").

[133] Montague, *Considerations*, *supra* note 111, at 3.

[134] 15 U.S.C. § 18a (known as the Hart-Scott-Rodino Antitrust Improvements Act of 1976).

[135] CTRS. FOR MEDICARE & MEDICAID SERVS., Hospital Change of Ownership (CHOW) Data Guidance (2022), https://data.cms.gov/sites/default/files/2023-01/Hospital_CHOW_Data Guidance_2022.12.30.pdf.

[136] Montague, *Considerations*, *supra* note 111, at 9.

[137] NAT'L ACAD. FOR STATE HEALTH POL'Y, *States' Efforts to Understand and Address Health Care Consolidation*, NASHP (Dec. 13, 2024), https://nashp.org/states-efforts-to-understand-and-address-health-care-consolidation/.

control of a hospital or other health care service provider, including transactions involving both nonprofit and for-profit parties.[138]

Under these systems, the state authority has the power to receive notice of a proposed transaction, review it, and then approve or deny it.[139] These notice, review, and approve systems generally permit the authority to approve the transactions, subject to conditions the authority chooses to impose.[140] These conditions may include any number of requirements, such as requiring a provider to agree to accept Medicaid patients, prohibiting them from imposing non-compete agreements on physicians, or requiring the provider to agree not to discontinue certain services, such as emergency departments and labor and delivery units.[141]

New Mexico now has perhaps the most robust oversight and approval program among the states following its legislature's 2025 amendment of the Health Care Consolidation Oversight Act (HCCO).[142] The HCCO is targeted at certain transactions involving private, non-university hospitals.[143] Under the HCCO, covered proposed transactions must be submitted to the New Mexico Health Care Authority (the "Authority"). The Authority may then approve, deny, or conditionally approve the transaction.[144] The covered transactions include mergers, transfers, various change-of-control transactions, and certain acquisitions by health insurers.[145]

For a transaction to be approved, three requirements must be met. First, the parties must demonstrate that the transaction will benefit the public by either (a) reducing the growth in patient costs, including premiums and out-of-pocket costs, or (b) maintaining or increasing access to services, especially in medically underserved areas.[146] Second, the proposed transaction must improve health outcomes for New Mexico residents.[147] Third, there must be no substantial likelihood of either (a) a significant reduction in the availability, accessibility, affordability, or quality of care for patients and other health care consumers, or (b) anti-competitive effects from the proposed transaction that

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[138] *See*, *e.g.*, Cal. Health & Safety Code §§ 127507–127507.6 (2021); Mass. Gen. Laws Ann ch. 6D, § 13 (2025); Or. Rev Stat Ann. § 415.500 (2022).

[139] *Id*.

[140] Montague, *Considerations*, *supra* note 111, at 7.

[141] *Id*. at 7–10.

[142] N.M. Stat. Ann. §§ 24A-9-1–24A-9-11 (2025).

[143] *Id*. § 24A-9-2.

[144] *Id*. § 24A-9-7.

[145] *Id*.

[146] *Id*.

[147] *Id*.

outweigh the transaction's benefits.[148] Although the standard review period is 120 days, if the Authority determines that it "is urgently necessary to maintain the solvency of a hospital or if there is an emergency that threatens the continued provision of immediate health care service . . . the Authority may agree to an immediate approval of a transaction with or without conditions."[149] After the closing of a transaction, the acquiring entity must submit annual reports to the Authority and to the Office of the Superintendent of Insurance for a three-year period.[150]

Oregon also has a robust oversight program, following its legislature's creation of the Health Care Market Oversight (HCMO) program, launched in 2022.[151] This law provides that the Oregon Health Authority (OHA) is to review material transactions[152] involving health care entities, including hospitals, health insurance companies, and provider groups.[153] It can then approve, deny, or conditionally approve those transactions.[154] The OHA is guided by the policies of the Oregon Health Policy Board, a nine-member citizen panel.[155] In addition, OHA may organize a Community Review Board to help review transactions, which must include members from the communities affected by the transaction.[156]

Although the standard review period is 180 days, the OHA may grant expedited consideration if "(a) [t]here is an emergency situation, including but

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[148] *Id*.

[149] *Id*. § 24A-9-6.

[150] *Id*. § 24A-9-8.

[151] Or. Rev. Stat. § 415.500 (2025).

[152] Or. ADC 409-070-0015 (2025).

[153] A "health care entity" includes: individual health professionals licensed or certified in Oregon; hospitals and hospital systems; carriers offering health benefit plans in Oregon; Medicare Advantage plans; coordinated care organizations (CCOs) and prepaid managed care health services organizations. Or. Rev. Stat. § 415.500(4)(a). It also includes "any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services." *Id.*

As such, the HCMO covers transactions involving a wide range of health care providers rather than applying only to hospitals. However, unlike New Mexico's HCCO Act, the HCMO has a revenue threshold that triggers its application. Specifically, it must involve at least one party that had average revenue of $25 million or more in the preceding three fiscal years and another party either who (a) had average revenue of at least $10 million in the preceding three fiscal years, or (b) for new entities, is projected to have at least $10 million in revenue in its first full year of normal operation. *Id*.

[154] Or. Rev. Stat. § 415.501 (2025).

[155] Or. Rev. Stat. § 415.501(2); *see also* Oregon Health Auth*., Oregon Health Policy Board, State of Or.*, https://www.oregon.gov/oha/ohpb/pages/index.aspx.

[156] Or. Rev. Stat. § 415.501.

not limited to a public health emergency, which immediately threatens health care services; and (b) [t]he transaction is urgently needed to protect the interest of consumers and to preserve the solvency of an entity other than a domestic health insurer."[157] Finally, the HCMO program provides for post-closing monitoring by the OHA for five years and requires OHA to make its post-closing analysis available online.[158]

As part of regulating transactions, some states are implementing or reviving corporate practice of medicine laws, which regulate the ownership and decision-making arrangements of health care facilities.[159] For example, in 2025, California specifically addressed private-equity investors in newly enacted legislation. This statute prohibits "[a] private equity group or hedge fund involved in any manner with a physician or dental practice doing business in this state" from "[interfering] with the professional judgment of physicians or dentists in making health care decisions."[160] It also prohibits such actors from exercising control over certain operational decisions, such as making staffing decisions, setting contract terms with third party payors or with other physicians or dentists, and approving the selection of medical equipment and supplies.[161]

III. Outsourcing Health Care

This Part contextualizes the issue by highlighting the scale and the magnitude of the shift away from publicly owned and controlled hospitals in the United States to privately controlled hospitals and some of the potential consequences of that shift. These consequences occur even before a distressed hospital seeks protection in bankruptcy, and some of them may, in fact, contribute to the future financial distress of the facility. It first describes this privatization movement and then presents some of its potential effects. The discussion does not always differentiate between private, for-profit facilities and private, nonprofit facilities because the academic literature and research do

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[157] Or. A.D.A. 409-070-0022.

[158] Or. Rev. Stat. § 415.501.

[159] Chris Cumming, *State Lawmakers Seek to Revive Bans on Corporate Control of Medical Providers*, WALL ST. J. (Feb. 27, 2025, 6:30 AM), https://www.wsj.com/articles/state-lawmakers-seek-to-revive-bans-on-corporate-control-of-medical-providers-55f57438.

[160] Cal. Health & Safety Code § 1191 (2025).

[161] *Id*. Recently amended legislation in Oregon similarly disrupts private-equity investment. This statute prohibits management services organizations (MSOs) from owning or controlling a majority of shares in professional medical entities, exercising voting proxies, or exercising "de facto control over administrative, business or clinical operations" that affects clinical decision-making. Or. Rev. Stat. § 676.555.

not always distinguish between the two forms of private governance,[162] or may find little or no difference when such differences are considered.[163]

A. The Shift Away from Public Hospitals

Public control over hospitals in the United States has decreased dramatically over the last three decades. Between 1983 and 2019, public control over general acute care hospitals declined by more than 40%.[164] Data from the American Hospital Association 2026 Annual Survey shows that 82% of hospitals in the United States are now controlled by private, nonprofit, or for-profit organizations, with 58% being nonprofit, non-government-owned firms and 24% being investor-owned, for-profit firms.[165]

Municipalities frequently choose to privatize a public hospital as a response to financial distress.[166] Financially distressed public hospitals are

[162] The term "conversion" may be used to describe various restructuring transactions by public hospitals. "For example, leases, asset sales, closures, mergers, consolidations, affiliations, and joint-ventures are all characterized as conversions in the relevant literature." ECON. & SOC. RSCH. INST., PRIVATIZATION OF PUBLIC HOSPITALS, 83 (Henry J. Kaiser Fam. Found. Jan. 1999) [hereinafter KFF PRIVATIZATION]. Further, the entity that assumes either ownership or management of a former public hospital might be purely private, such as a non-profit or for-profit corporation or quasi-public, such as a hospital authority or a public-private partnership. *Id*. The extent to which state or local leaders continue to exercise control over or otherwise be involved in the operations of these quasi-public entities "varies and is determined by state law or the contract between the parties." *Id*.

[163] While some defenders of nonprofits assert that nonprofit hospitals are valuable because they produce lower costs, higher quality, and other community benefits compared to their for-profit counterparts, empirical research has found mixed results on these points. Lauren A. Taylor, *et al*., *Public Perceptions of US For-Profit, Nonprofit, and Public Hospitals*, 1 HEALTH AFFS. SCHOLAR qxad046 (2023), https://doi.org/10.1093/haschl/qxad046. Identifying the potential operational distinctions between private, nonprofit facilities, on the one hand, and private, for-profit facilities, on the other, appears to require a nuanced inquiry. For example, one relevant factor that may affect the extent to which nonprofit hospitals resemble public rather than for-profit hospitals is how closely their management practices mirror those of for-profit firms. As one researcher observes, "[n]onprofit hospitals have been criticized for behaving like for-profit hospitals" and "for failing to live up to a poorly articulated standard of 'charity care' and general benevolence." *Id*.

[164] Mark Duggan *et al*., *The Impact of Privatization: Evidence from the Hospital Sector*, Nat'l Bureau of Econ. Rsch., Working Paper No. 30824, 1 (Jan. 2023, rev. Sept. 2024) [hereinafter Duggan, *Impact*].

[165] Am. Hosp. Ass'n, *Fast Facts on U.S. Hospitals, 2026* (Health Forum LLC Jan. 2026).

[166] KFF PRIVATIZATION, *supra* note 162 (noting that of the case studies it examined, "hospitals converted to private ownership or management to recover from or avert financial difficulties, due largely to increased competition for patients and revenue and changes in reimbursement caused by the growth of managed care").

significantly more likely to be privatized, and such transactions can relieve municipalities of the burden of subsidizing loss-making facilities while preserving continued operations.[167] Even when a public facility is privatized, however, whether by outright transfer of ownership or by government contracting with a private operator to provide the care,[168] public funding in some form nonetheless continues to be directed to the privatized entity. This funding may come from tax incentives, Medicaid or Medicare payments, management fees, or other public revenue streams.

Governmental actors may also delegate health care responsibilities to private actors through transactions that do not involve an outright sale of the facility. For example, the local government may retain ownership of a facility but contract a private entity to operate the hospital.[169] Under this structure, the governmental entity transfers operational control of the facility to a private company created to operate the hospital, while continuing to oversee the entity.[170] Under another structure, the governmental entity may retain ownership of the hospital while entering into a long-term lease with a private entity to operate the hospital.[171] A long-term lease term is generally more than fifteen years.[172] This arrangement typically gives the private entity greater autonomy to make changes to the buildings and equipment, as well as greater operational control.[173] Under a third approach, the governmental entity may enter into a joint venture agreement with a private entity that can be structured to give the private entity significant control over both the operations and the assets.[174] An approach that transfers control without transferring ownership may be preferred in states in which the sale of a public hospital requires legislative approval.[175]

Since 2010, private equity firms, driven by profit maximization, have been aggressively acquiring hospitals and other health care facilities.[176] Initially

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[167] Zo Ramamonjiarivelo *et al*., *Public Hospitals in Financial Distress: Is Privatization a Strategic Choice?*, 40 HEALTH CARE MGMT. REV. 337, 338–39, 343 (2015).

[168] KFF PRIVATIZATION, *supra* note 162.

[169] Duggan, *Impact*, *supra* note 164, at 9.

[170] *Id.*

[171] *Id.*

[172] *Id.*

[173] *Id.*

[174] *Id.*

[175] *Id.*

[176] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?* (Inst. for New Econ. Thinking, Working Paper No. 118, Mar. 15, 2020), at 4 [hereinafter Appelbaum, *Private Equity Buyouts*], https://cepr.net/wp-content/uploads/2020/03/WP_118-Appelbaum-and-Batt.pdf.

focused on nursing homes and hospitals, these firms have expanded into specialized physician services, outpatient care, and home health care.[177] Approximately 8.5% of all private hospitals are owned by private equity firms.[178] Private equity firms own 22.6% of all for-profit hospitals.[179] Some states have a higher concentration of private equity-owned hospitals than others. New Mexico has the highest proportion of private equity-owned hospitals at 36.2%.[180]

Beyond the increase in privatization, the ownership and control of health care systems are also becoming increasingly consolidated, driven largely by private equity mergers and acquisitions.[181] As discussed below, consolidation and reduced competition in health care markets can drive up prices without delivering corresponding improvements in the quality of care for patients.[182] This consolidation includes both horizontal consolidation, which involves merging similar entities (such as hospital-to-hospital mergers), and vertical consolidation, which involves a firm acquiring different levels of care (such as hospitals buying physician practices).[183]

With respect to horizontal consolidation, starting in the late 1990s, hospitals increasingly consolidated into large health systems, many of which span across multiple states.[184] By 2016, 90% of hospital markets in the U.S. were deemed "highly concentrated," indicating that a large percentage of the market in an area is dominated by a small number of providers.[185] From 2015

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[177] *Id*.

[178] Private Equity Stakeholder Project, *Private Equity Hospital Tracker* (Apr. 2025), https://pestakeholder.org/private-equity-hospital-tracker/.

[179] *Id*.

[180] *Id*.

[181] Appelbaum, *Private Equity Buyouts*, *supra* note 176, at 17–21.

[182] W. Pete Welch *et al.*, *Ownership of Hospitals: An Analysis of Newly-Released Federal Data & A Method for Assessing Common Owners*, Issue Brief No. HP-2023-14, Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Hum. Servs. (2023).

[183] *See* Jessica Heeringa *et al., Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organizational Structures*, 20 INT'L J. INTEGRATED CARE 2, 2 (2020).

[184] Erin C. Fuse Brown et al., *The Rise of Health Care Consolidation and What to Do About It*, HEALTH AFFS. FOREFRONT (Sept. 9, 2024), https://www.healthaffairs.org/content/forefront/rise-health-care-consolidation-and-do.

[185] *Id.* The Herfindahl–Hirschman Index is a commonly accepted measure of market concentration. It is "calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2,600 (302 + 302 + 202 + 202 = 2,600)." Herfindahl-Hirschman Index, U.S. Dep't of Just., https://www.justice.gov/atr/herfindahl-hirschman-index (last updated Jan. 17, 2024). A market with an HHI higher than

to 2024, hospital markets in 80% of metropolitan areas became less competitive or were controlled by one health system over that entire period.[186] Further, by 2024, for almost half of all metropolitan areas (47%), one or two health systems controlled the entire market for inpatient hospital care.[187]

Operators have also aggressively engaged in vertical consolidation in recent years. For example, a 2025 Government Accountability Office report notes that studies indicate that physician practices have been steadily acquired by hospital systems, insurance companies, private equity firms, and other entities.[188] In 2012, 30% of physician practices were consolidated with hospital systems.[189] That percentage increased to 47% by 2024.[190]

B. Privatization and the Impact on Hospital Operations

Although the privatization of hospitals and other health care facilities has become increasingly common in recent decades, its impact on hospital operations is understudied.[191] This subsection will highlight some of the potential effects.

Some studies suggest that converting to a private governance structure improves efficiency but may negatively affect access to health care for some and increase costs.[192] These studies suggest that private operators may increase revenue by selectively choosing the patients they treat and the services they provide. First, they may choose to treat fewer low-income patients to lessen the risk of nonpayment or delayed payment, thus reducing access to health care for low-income or uninsured populations.[193] Additionally, they may prioritize

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1,800 points is considered to be highly concentrated. *Id*.

[186] Jamie Godwin *et al*., *One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024*, KFF (Mar. 27, 2026), https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas.

[187] *Id*.

[188] U.S. GOV'T ACCOUNTABILITY OFF., *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation*, GAO-25-107450, 1 (2025).

[189] *Id*. at 16–17.

[190] *Id*.

[191] *Id.* at 1; Benjamin Goodair & Aaron Reeves, *The Effect of Health-Care Privatisation on the Quality of Care*, 9 LANCET PUB. HEALTH e199 (2024) [hereinafter Goodair, *Effects on Quality*]; Tareq M. Alayed *et al*., *Impact of Privatization on Healthcare System: A Systematic Review*, 12 SAUDI J. MED. & MED. SCI. 125, 126 (2024) [hereinafter Alayed, *A Systematic Review*].

[192] Alayed, *A Systematic Review, supra* note 191, at 128–29.

[193] *Id*. at 126.

profitable services, shifting resources away from more complex care or otherwise less profitable services.[194]

The impact of converting to a private governance structure on quality of care is difficult to evaluate. In part, this is because such facilities tend to treat patients who are healthier and have more resources.[195] "Consequently, in comparing outcomes in public and private hospitals, it will be difficult to control for the bias of healthier patients being selected in private hospitals and having better outcomes, not because of the quality of care, but because of these patients' underlying health status."[196] A 2024 systematic review of longitudinal studies sought to address these limitations by examining studies evaluating health care privatization in high-income and upper-middle-income countries. It found that studies support that hospitals that convert from public to private governance structures tend to increase profitability primarily through cost-cutting strategies such as reducing staffing levels and selectively treating more profitable patients, often at the expense of access for lower-income populations.[197] The review further concluded that greater reliance on privatization is generally associated with worse health outcomes, including higher rates of avoidable mortality and hospital-acquired infections, and that no study in the review demonstrated improved patient health outcomes attributable to privatization.[198] Significantly, the review found that "transitions to for-profit provision typically resulted in larger declines in the quality of care, as compared with transitions to non-profit status, but transitions to not-for-profit private organisations also frequently resulted in declines in health-care quality."[199]

Regarding the impact of privatization on financial performance, this review observed that, although cost-effectiveness was not the focus of its review, "there was a trend—among the articles that reported some measure of health-care quality—that the profit margins of hospitals that converted to for-profit status tended to rise. However, hospitals that converted to for-profit status had, on average, much worse financial performance than the public hospitals that remained public."[200] These observations led the authors to determine that, "more work needs to be done to better understand effects [of privatization] on financial performance."[201]

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[194] *Id*. at 126–27.
[195] *Id*.
[196] *Id*.
[197] Goodair, *Effects on* Quality, *supra* note 191, at e201.
[198] *Id*.
[199] *Id*. at e204.
[200] *Id*. at e203.
[201] *Id*.

Ultimately, the findings of this review led the authors to conclude that existing evidence provides little support for further privatization of health care services.[202] They also caution that without private providers facing effective incentives to prioritize the quality of patient care, "they might implement policies that make—what are perceived to be—marginal sacrifices in quality in return for large reductions in cost, such as reducing staff, lowering staff pay, selectively choosing profitable patients, over-prescribing services, or discharging patients prematurely."[203]

The risks associated with privatization are only exacerbated by the proliferation of private equity in the ownership and control of hospital facilities. Hospitals and other health care facilities are attractive investments for private equity because they promise high returns with lower risk.[204] Private equity firms generally acquire hospitals and other health care companies through leveraged buyouts, typically financing about 70% of the purchase price with borrowed funds secured by the target company's own assets.[205] The acquired company, not the private equity firm, is responsible for repaying this debt.[206] After acquisition, the private equity firm generally installs management and imposes aggressive cost-cutting and performance targets.[207] For example, measures taken may include increasing patient volume and promoting high-revenue procedures while cutting staff and decreasing or eliminating less lucrative care.[208]

Additionally, the private equity firm often extracts value from the acquired health care facility through various arrangements it imposes on the acquired health care company. For example, the private equity firm may require the acquired company to enter into a sale-leaseback transaction, in which it sells its land to a third party to generate cash to pay the private equity shareholders, then leases the property from that third party.[209] Similarly, the private equity firm may require the acquired company to undertake a dividend recapitalization, prompting it to take on debt to generate cash to pay to the private equity firm.[210] These strategies shift resources from the acquired

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[202] *Id*. at e205.
[203] *Id*. at e199.
[204] Appelbaum, *Private Equity Buyouts, supra* note 176, at 7–8, 15–16.
[205] *Id.* at 6.
[206] *Id.*
[207] *Id.*
[208] *Id.* at 6–7, 25.
[209] *Id.* at 6–7.
[210] *Id.* at 7.

company to the private equity firm, and may leave the acquired company highly leveraged and vulnerable to financial distress.

Another revenue-generating strategy used by many private equity firms is the consolidation of hospitals and other services. Under this approach, the firm first acquires a larger platform company and then engages in a series of horizontal mergers between the original platform company and its smaller rivals.[211]This maneuver can reduce competition in health care markets, which can drive up prices.[212]

As one researcher observes, as a general matter, the private equity model "contrasts sharply with how publicly traded companies operate. Shareholders in publicly traded companies expect them to be going concerns that create shareholder value for the foreseeable future. CEOs of these companies are hired by independent boards and typically have a substantial history of related management experience and success."[213] The tactics private equity firms use to siphon money away from the acquired company are not available to a publicly traded company.[214] Further, "[p]ublic shareholders would flee a company that loaded itself with debt equal to 70 percent of its enterprise value—or one that issued junk bonds to pay dividends."[215]

Not surprisingly, private equity-backed firms default at almost twice the rate of non-private equity-backed firms.[216] Additionally, private equity-owned firms accounted for 44% of the largest health care bankruptcies in 2025.[217] As noted above, some hospitals engage in sale-leaseback transactions in which they sell their real property to a third party and lease it back. Both private

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[211] *Id*. at 11.

[212] Karyn Schwartz et al., *What We Know About Provider Consolidation* (KFF Sept. 2, 2020), https://www.kff.org/health-costs/what-we-know-about-provider-consolidation ("A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance; this is true for both horizontal and vertical consolidation.").

Consolidation may also have a negative impact on the quality of care. Although some point to the promise of greater efficiencies and coordination of care from consolidation "evidence of the benefits of improved quality after a merger are mixed at best, and some studies suggest that market consolidation—particularly for horizontal consolidation—can actually lead to lower quality care." *Id*. With respect to vertical consolidation, "many studies showing that quality does not improve (or gets worse) after vertical integration, while some analysis has shown modest improvements." *Id*.

[213] Appelbaum, *Private Equity Buyouts, supra* note 176, at 7.

[214] *Id.*

[215] *Id.*

[216] Matt Parr, *Private Equity's Role in Healthcare Bankruptcies Resurfacing*, Private Equity Stakeholder Project (Feb. 25, 2026), https://pestakeholder.org/news/private-equitys-role-in-healthcare-bankruptcies-resurfacing/.

[217] *Id*.

equity-backed hospitals and other hospitals engage in these transactions to free up capital.[218] Real estate investment trusts (REITs) often serve as the landlord.[219] One study found that the risk of closure or bankruptcy for REIT-acquired hospitals was nearly 5.7 times higher than for non-REIT-acquired hospitals.[220]

C. Summary Observations

One important takeaway from this discussion is that, well before a future bankruptcy filing, the conversion from a public hospital to a private hospital structure may mean that the quality or availability of vital health care services in a community may suffer.

As such, state and local authorities should be mindful that private facilities may prioritize profits over the quality and availability of care in an affected community. Additionally, they may need to take proactive steps to ensure that the interests of community residents are protected, whether by avoiding privatization, implementing and enforcing some of the safeguards identified above, or considering other transaction conditions and governance arrangements that preserve governmental or community input.

Another important takeaway is that private governance or ownership should not be assumed to be a proxy for financial stability. In fact, private investors, many of whom may have no connection to the community where a facility is located, may make decisions that threaten the facility's financial viability. If distress follows, the community bears the risk of service loss even as value may already have been siphoned away to sponsors, affiliates, landlords, or lenders. Privatization, particularly in the for-profit form, can therefore mute resident voice by removing political accountability and displacing the public-interest mission, while simultaneously increasing the likelihood of bankruptcy.

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[218] Maya Brownstein, *Hospitals Acquired by Real Estate Investment Trusts Associated with Greater Risk of Bankruptcy, Closure*, Harv. T.H. Chan Sch. Pub. Health (Dec. 18, 2025), https://hsph.harvard.edu/news/hospitals-acquired-by-real-estate-investment-trusts-associated-with-greater-risk-of-bankruptcy-closure/.

[219] *Id*.

[220] Joseph Dov Bruch *et al*., *Changes in Hospital Financial Performance and Quality of Care After Real Estate Investment Trust Acquisition: Quasi-Experimental Difference-in-Differences Study*, 391 BMJ e086226, 5 (2025), https://doi.org/10.1136/bmj-2025-086226.

IV. Hospitals in Bankruptcy and Resident Voice

Because protecting public health and safety is a core state police power, decisions about community access to hospital care implicate state health care authority and, when delegated to local municipalities, local responsibility for preserving essential services. This Part examines how resident voice manifests in a collection of hospital bankruptcy cases, some filed under chapter 9 and others filed under chapter 11. It examines the extent to which residents are given a voice in the proceedings, either directly or indirectly through their elected representatives, and the extent to which various state and local governmental actors, as well as the federal bankruptcy court, may coordinate to advance the public interest.

A. Mediated Voice

Whether a case is filed under chapter 9 or chapter 11, the right to be heard is governed by § 1109 of the Bankruptcy Code, incorporated into chapter 9 by § 901(a).[221] Section 1109(b) gives a party in interest the right to "appear and be heard on any issue in a case in this chapter."[222] The term includes "the debtor, the trustee, a creditors' committee, an equity security holders' committee, a creditor, an equity security holder, or any indenture trustee," but the enumerated list is not exhaustive.[223]

The phrase "party in interest" is intended to be broadly construed.[224] "The general theory behind § 1109(b) is that anyone holding a direct financial stake in the outcome of the case should have an opportunity (either directly or through an appropriate representative) to participate in the adjudication of any issue that may ultimately shape the disposition of his or her interest."[225] "[M]any courts have concluded that the party requesting standing must either be a creditor of a debtor . . . or be able to assert an equitable claim against the estate."[226]

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[221] 11 U.S.C. § 1109; 11 U.S.C. § 901(a) (incorporating 11 U.S.C. § 1109).

[222] *Id*. § 1109(b). In addition, § 1109(a) permits the Securities and Exchange Commission to appear and be heard on any issue but the SEC "may not appeal from any judgment, order, or decree entered in the case." *Id*. § 1109(a).

[223] *Id*.; *see also In re* Barnwell Cnty. Hosp., 459 B.R. 903, 906 (Bankr. D.S.C. 2011).

[224] Truck Ins. Exch. v. Kaiser Gypsum Co., Inc., 602 U.S. 268, 278 (2024).

[225] *Id*. at 277–78 (2024) (*quoting* 7 Collier on Bankruptcy ¶ 1109.01 (16th ed. 2023)) (internal quotation marks omitted); *see also In re* Suffolk Regional Off-Track Betting Corp., 462 B.R. 397, 403 (2011).

[226] *In re* City of Detroit, 504 B.R. 97, 139 (Bankr. E.D. Mich. 2013) (*quoting In re* Wolf Creek Valley Metro. Dist. No. IV, 138 B.R. 610, 615 (D. Colo. 1992)) (internal quotation marks

Additional provisions may confer the right to appear on behalf of other parties in certain hospital cases.[227] One such provision allows for the appointment of a patient care ombudsman in any case in which the debtor is a business designated as a "health care business" under Federal Rule of Bankruptcy Procedure 1021.[228] Specifically, § 333 of the Bankruptcy Code provides that if the debtor is a "health care business," the bankruptcy court "shall order . . . the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business."[229] That appointment is required, "unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."[230]

The patient care ombudsman is required to "monitor the quality of patient care" and provide a report to the court every 60 days regarding the status of patient care.[231] The patient care ombudsman's role as representative of the interests of patients, "is broad enough to allow the ombudsman to review virtually every business decision a health care business debtor makes, so long as the ombudsman can articulate an 'interest' of the patients in the outcome of

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omitted).

[227] The Federal Rules of Bankruptcy Procedure also confer standing on certain parties. With respect to a chapter 9 case, Rule 2018 provides that "[t]he Secretary of the Treasury of the United States may, or if requested by the court shall, intervene in a chapter 9 case." Fed. R. Bankr. P. 2018(c). It also provides that, "[r]epresentatives of the state in which the debtor is located may intervene in a chapter 9 case." *Id*. With respect to a case under chapter 11, Rule 2018 provides that, "[i]n a chapter 7, 11, 12, or 13 case, a state attorney general may appear and be heard on behalf of consumer creditors if the court determines that the appearance is in the public interest. But the state attorney general may not appeal from any judgment, order, or decree entered in the case." *Id*. 2018(b). Additionally, "[a] special tax payer may object to confirmation of a plan." 11 U.S.C. § 943. For purposes of chapter 9, "a 'special tax payer' means record owner or holder of legal or equitable title to real property against which a special assessment or special tax has been levied the proceeds of which are the sole source of payment of an obligation issued by the debtor to defray the cost of an improvement relating to such real property." 11 U.S.C. § 902(3).

However, this provision does not confer standing for them to appear generally in the proceedings. *In re* Addison Cmty. Hosp. Auth., 175 B.R. 646, 651 (Bankr. E.D. Mich. 1994).

[228] Fed. R. Bankr. P. 1021.

[229] 11 U.S.C. § 333(a).

[230] *Id*.; *see also In re* Valley Health Sys., 381 B.R. 756, 761–762, 765 (Bankr. C.D. Cal. 2008) (holding that the appointment of a patient care ombudsman was not necessary under the specific facts of the case, when, among other factors, "[t]he District is subject to substantial monitoring by a variety of federal and state regulatory agencies and independent accreditation associations").

[231] *Id*. § 333(b).

the decision.'"[232] Accordingly, the patient care ombudsman is permitted to "review and comment on decisions such as the closure of any facility, the sale of any portion of the facility and the increase or decrease in the scope of any services rendered by a health care business to its patients."[233]

State attorneys general or other state regulators generally have the right to be heard in their role as state public health officials. One important example involves asset sales or transfers. State law may require the attorney general or another health official to review and approve the sale of hospitals or hospital assets. Section 363(d)(1) provides specifically that, in the case of nonprofit debtors, the trustee may sell assets "only in accordance with nonbankruptcy law applicable to the transfer of property by a debtor that is such a corporation or trust."[234] Additionally, § 363(f)(1) provides in relevant part that the trustee may sell assets "free and clear of any interest in such property . . . only if applicable nonbankruptcy law permits sale of such property free and clear of such interest."[235] Similarly, the requirements for plan confirmation in both chapter 9 and chapter 11 include provisions that require compliance with applicable law.[236] As such, state law licensing and other regulations and requirements often mean the state attorney general or other designated public health official may be engaged in proceedings involving the sale or other transfer of assets.[237]

The state attorney general or another public health official may participate in a debtor hospital's bankruptcy case regarding issues pertaining to the automatic stay under § 362 of the Bankruptcy Code.[238] Absent certain limited exceptions, the automatic stay, which applies in both chapter 9 and chapter 11 cases, immediately halts most actions against the debtor or the

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[232] 3 COLLIER ON BANKRUPTCY ¶ 333.04 (16th ed. 2026).

[233] *Id*.; *see also In re* Saint Vincents Cath. Med. Centers of New York, 429 B.R. 139, 151 (Bankr. S.D.N.Y. 2010) (noting that the patient care ombudsman "may have standing to object to any action by the Debtors whereby patients are put at risk").

[234] 11 U.S.C. § 363(d)(1).

[235] *Id*. § 363(f)(1).

[236] *See*, *e.g*., *id*. § 943(b)(4) (providing that for a plan to be confirmed, the debtor must "not [be] prohibited by law from taking any action necessary to carry out the plan"); *id*. § 943(b)(6) (providing that for a plan to be confirmed "any regulatory or electoral approval necessary under applicable nonbankruptcy law in order to carry out any provision of the plan [must have] been obtained, or such provision [must be] expressly conditioned on such approval"); *id*. § 1129 (a)(3) (providing that, for a plan to be confirmed, the plan must have "been proposed in good faith and not by any means forbidden by law"); *id*. § 1129 (a)(16) (providing that "[a]ll transfers of property under the plan shall be made in accordance with any applicable provisions of nonbankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust").

[237] *See infra* Part IV.D.

[238] 11 U.S.C. § 362(a).

debtor's assets, including lawsuits, foreclosures, and garnishments, at the moment the debtor's bankruptcy petition is filed.[239] However, the automatic stay does not generally bar a "governmental unit's" enforcement of its "police and regulatory power, including the enforcement of a judgment other than a money judgment, obtained in an action or proceeding by the governmental unit to enforce such governmental unit's or organization's police or regulatory power."[240]

Regarding the right of residents who live in the community serviced by the debtor-hospital, the information website maintained by the Federal Courts states that, in a chapter 9 case, "[p]arties in interest include municipal employees, *local residents*, non-resident owners of real property, special tax payers, securities firms, and local banks."[241] In the chapter 9 bankruptcy case of Barnwell County Hospital, however, the court expressly rejected that broad construction of § 1109.[242] In that case, the court considered whether a committee of concerned citizens, formed to attempt to keep the hospital open and operating at its current location, had the right to appear and be heard in the case.[243] The court held that the group did not have the right to appear because, among other things, they had not asserted any injury distinct from that suffered by all the county's residents.[244] The court did observe that "there may be some instances in which local residents would meet the requirements for standing and would be entitled to party in interest status," but that "[t]he Committee's request to test Debtor's eligibility is not such a case."[245] The court also observed that, "allowing the Committee the opportunity to be heard would invite all other residents of Barnwell County not already included to come join the proceedings. . . . Allowing all citizens to be heard in Debtor's eligibility proceeding would not be productive for anyone involved, but would merely cause confusion and delay."[246]

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[239] *Id*.

[240] *Id*. § 362(b)(4). Similarly, § 362(b)(28) provides expressly that "actions taken by the Secretary of Health and Human Services to exclude a debtor from participating in a federal health care program do not violate the stay.

[241] Chapter 9—Bankruptcy Basics, U.S. CTS., https://www.uscourts.gov/court-programs/bankruptcy/bankruptcy-basics/chapter-9-bankruptcy-basics (emphasis added).

[242] *In re* Barnwell Cnty. Hosp., 459 B.R. 903, 910 (Bankr. D.S.C. 2011).

[243] *Id*. at 910; *see also In re* Addison Cmty. Hosp. Auth., 175 B.R. 646, 650 (Bankr. E.D. Mich. 1994) ("By allowing a large number of non-creditors to be heard in this action, the Court would be granting a blanket invitation to all parties in the area serviced by Addison. This would hamper, and unduly delay, the debt adjustment process.").

[244] *In re* Barnwell Cnty. Hosp., 459 B.R. 903, 909 (Bankr. D.S.C. 2011).

[245] *Id.*

[246] *Id.*

Similarly, in the case of Addison Community Hospital Authority, a group of concerned citizens from the area served by Addison sought recognition as parties in interest in the debtor's chapter 9 case.[247] All the citizens in the group were taxpaying owners of real property, and some were trade creditors of the debtor.[248] The citizens sought to intervene in the case, asserting they had standing to intervene because "its members will be affected as taxpayers in the event that more taxes are required. In the alternative, it will be affected if the hospital is transferred out of the hospital authority to a private profit-making entity that is not bound by the Act or the by-laws [of the public hospital]."[249] The court held that the creditor members of the group had standing in that capacity.[250] With respect to the other citizen members of the group, the court held that they lacked standing. The court explained that, "[w]here a party is merely interested in the outcome of the matter and does not have a direct legal interest in the chapter 9 proceeding, that party is not a 'party in interest.'"[251] The court also observed that, "[b]y allowing a large number of non-creditors to be heard in this action, the Court would be granting a blanket invitation to all parties in the area serviced by Addison. This would hamper, and unduly delay, the debt adjustment process."[252]

Thus, it seems unlikely, and perhaps unworkable, for community residents to have the right to appear and be heard in the case in their individual capacity as residents. Rather, residents likely must depend on their elected representatives, or other institutional actors, to advance their interests.[253]

B. Multiple Voices

Even when residents speak through elected representatives or other institutional actors, the community's voice is not necessarily unified. Residents themselves may disagree about what outcome best serves the community, and

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[247] *In re* Addison Cmty. Hosp. Auth., 175 B.R. 646, 648 (Bankr. E.D. Mich. 1994).
[248] *Id.*
[249] *Id.*
[250] *Id.* at 650.
[251] *Id.*
[252] *Id.*
[253] Skyywalker Recs., Inc. v. Navarro, 739 F. Supp. 578, 587 (S.D. Fla. 1990) ("In our democratic form of government, citizens elect representatives to protect their interests and promote their welfare [and] [s]tate legislatures have the authority to exercise the governmental police power."), *rev'd sub nom.* Luke Recs., Inc. v. Navarro, 960 F.2d 134 (11th Cir. 1992); Marks v. Stinson, 19 F.3d 873, 887 (3d Cir. 1994) ("The people, the ultimate source of governmental power, delegate to their elected representatives the authority to take measures which affect their welfare in a multitude of important ways.").

the positions advanced by their representatives—including their various local representatives—may overlap, diverge, or directly conflict. The relevant inquiries, therefore, are which actor has legal authority over the service or asset, whether that authority was assigned through ordinary democratic institutions and under ordinary conditions, and whether the relevant institutional processes permit affected communities to understand and challenge the position advanced in their name or otherwise hold the actor accountable for it.

The bankruptcy case of Jefferson County, Alabama[254] is illustrative. Jefferson County owned Cooper Green Mercy Hospital, which historically served indigent residents. During the County's chapter 9 case, the County decided to end inpatient and emergency-room services at Cooper Green.[255] The City of Birmingham, its mayor, and the City and mayor acting on behalf of the State of Alabama (collectively, the "State & City Parties"), sought a determination that the automatic stays under §§ 362(a) and 922(a) did not apply, or, alternatively, relief from those stays, so they could sue in Alabama state court to stop the closure.[256]

The State & City Parties argued that Alabama's Health Care Responsibility Act (the "Health Care Act") required the County to maintain services or establish an alternative system for indigent care.[257] They also argued that they were acting to protect indigent residents' access to health care and the general health, safety, and welfare of Birmingham residents. As such, they asserted that the "police power" exception to the automatic stay applied, so their actions were not stayed.[258] The central legal theory of the State & City Parties was that the Health Care Act required Jefferson County to do more than pay for indigent care; they claimed it required the County to maintain services or create an alternative system before closing Cooper Green's inpatient and emergency services.[259]

The bankruptcy court denied the relief requested by the State & City Parties. In considering whether the automatic stay applied or whether, alternatively, the police-power exception was applicable, the court explained that, in determining whether the exception applies, courts generally apply either the pecuniary purpose test or the public policy test, or both.[260] Under the pecuniary purpose test, courts consider "whether the governmental proceeding

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[254] *In re* Jefferson Cnty., Ala., 484 B.R. 427, 433–39 (Bankr. N.D. Ala. 2012).
[255] *Id*. at 433.
[256] *Id*. at 436–38.
[257] *Id*.
[258] *Id*. at 436–39, 452.
[259] *Id*. at 437–39, 441.
[260] *In re* Jefferson Cnty., Ala., 484 B.R. 427, 452 (Bankr. N.D. Ala. 2012).

at issue relates primarily to the protection of the government's pecuniary interest in the debtor's property, and not to matters of public safety."[261] The public policy test, the court explained, "distinguishes between proceedings that adjudicate private rights and those that effectuate public policy."[262] "Actions that are primarily related to public safety or the effectuation of public policy are exempt from the automatic stay."[263]

With respect to the Health Care Act, the court found that its purpose "is payment. It does not require counties to have programs in place to provide indigent care. It merely requires that if an indigent resident of a county receives covered, out-of-county hospital services, the county of residence must bear the cost."[264] So, because the Health Care Act only imposed a financial obligation on the County, "it is a statute creating a payment obligation of a county to a medical care provider. It does not involve any police or regulatory power as that phrase is used in 11 U.S.C. § 362(b)(4) and fails both the pecuniary purpose and public policy tests."[265]

In addition to illustrating the divergence of views between the various officials tasked with representing the interests of the residents of Birmingham and Jefferson County, the opinion reveals a second important point: when a state has delegated authority to one of its municipalities, the court will not necessarily defer to the state if the state later attempts to interfere with the authority that has been delegated to the municipality. Instead, the prevailing voice in a dispute with the state may be the municipality to which authority has been delegated.

In declining to grant the relief requested by the State & City Parties, the court repeatedly emphasized that the State of Alabama itself contributed to the financial distress that necessitated the hospital cuts. The court observed that "[c]ontrary to what many have written and what others have assumed . . . a major cause was actually beyond the County's control."[266] The court explained that a major cause was the loss of an occupational tax that had provided one of Jefferson County's few unearmarked revenue sources, helping fund the hospital's recurring deficits.[267]

The court traced the loss of that revenue to state legislative action and inaction. Alabama repealed the original occupational tax, enacted replacement

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[261] *Id*.
[262] *Id*.
[263] *Id*.
[264] *Id*.
[265] *In re* Jefferson Cnty., Ala., 484 B.R. 427, 452–53 (Bankr. N.D. Ala. 2012).
[266] *Id*. at 434.
[267] *Id*.

taxes that were successfully challenged, and then failed to enact a valid replacement source of unearmarked revenue for Jefferson County.[268] The court stated that the loss of this revenue "rest[ed] with the State of Alabama," not Jefferson County, and that one consequence was the County's inability to continue funding Cooper Green's deficits.[269] The court also observed that the "State of Alabama has not delegated to Jefferson County the authority to enact various and sundry taxes."[270] In sum, Alabama and its legislators were "a significant, precipitating cause" of the County's inability to fund the hospital operations.[271]

With that backdrop, the court noted that attempting to force the County to provide these hospital operations amounted to an effort to dictate how Jefferson County used its own property and would be inconsistent with the limits placed on the court under § 904.[272] Thus, even when the result would be the elimination of essential services and even over the objections of the state of Alabama and the city of Birmingham, the court would not encroach on the debtor's sovereign authority over its property or revenue. It is worth reiterating here that a municipality is not a sovereign entity separate from the state. As discussed above, its powers are delegated to it by the state. Nonetheless, here, because the state had authorized the chapter 9 filing and the county had become a debtor in chapter 9, the bankruptcy court respected the State's prior allocation of authority to the county.

C. Mission as a Proxy for Resident Voice

Nonprofit and public hospitals generally share a common foundational goal of serving the public good. Their service-delivery missions reflect community interests in a way that a for-profit hospital's profit-focused mission does not. The difference in mission between public and nonprofit hospitals, on the one hand, and for-profit hospitals, on the other, is reflected in the applicable plan confirmation standards and the standards for approving a sale under § 363. For purposes of resident voice, the enforcement of a service mission can operate as a proxy for community participation when a court gives legal significance to the debtor's obligation to continue providing essential health care. Of course, a mission is not itself a resident voice; a nonprofit board may be privately selected and politically unaccountable. But judicial and regulatory enforcement

[268] *Id*. at 434–36.
[269] *Id*. at 435–36.
[270] *In re* Jefferson Cnty., Ala., 484 B.R. 427, 435 (Bankr. N.D. Ala. 2012).
[271] *Id.* at 436.
[272] *Id*. at 462–64.

of a service mission can protect outcomes residents value and can operate as a proxy when direct participation is unavailable.

Although there are many examples,[273] the Hardeman County Hospital case[274] is illustrative. There, the bankruptcy court confirmed a plan over creditor objections, emphasizing that the hospital's statutory mission to provide care to local residents justified preserving essential health care services even at the expense of unsecured creditor recoveries.[275]

In *Hardeman County*, the court explained that to satisfy the "fair and equitable" standard in the context of a chapter 9 case, the creditor "must receive all they can reasonably expect under the circumstances of the Case."[276] This standard is a vast departure from the "absolute priority rule" applicable in a for-profit chapter 11 case, which, in simple terms, requires that all creditors be paid in full before equity holders can retain any interest in the debtor.[277] In the reorganization of a municipality or a non-profit corporation, the requirement "must be interpreted somewhat differently . . . [because] there are no holders of equity interests in the debtor."[278] The *Hardeman County* court explained that, under the standard applicable in chapter 9, in determining whether the creditors are receiving what they can reasonably expect, the hospital-debtor "must be allowed to retain sufficient funds with which to operate, make necessary improvements, and maintain its facilities."[279]

The court also found that the plan satisfied the "best interests of the creditors" requirement.[280] In the context of a chapter 11 plan, the best interests of creditors test is known as the liquidation test because the creditors must receive under the plan at least as much as they would if all the debtor's assets were liquidated and the proceeds distributed to creditors.[281] In a chapter 9 case, however, the debtor cannot be forced to liquidate. Rather, the court explained, "[t]he Plan is in the best interests of Creditors because it provides Creditors, as a whole, with a better alternative than dismissal of the Chapter 9 Case."[282]

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[273] Michael A. Francus, *Death, Bankruptcy, and the Public Hospital*, 41 YALE J. ON REG. 524 (2024).

[274] *In re* Hardeman Cnty. Hosp. Dist., 540 B.R. 229, 237 (Bankr. N.D. Tex. 2015).

[275] *Id*.

[276] *Id*. at 239.

[277] *In re* Cleary Packaging, LLC, 657 B.R. 780, 798 (Bankr. D. Md. 2023).

[278] *In re* Corcoran Hosp. Dist., 233 B.R. 449, 458 (Bankr. E.D. Cal. 1999).

[279] *In re* Hardeman Cnty. Hosp. Dist., 540 B.R. at 239.

[280] *Id*. at 241.

[281] *In re* Storage Masters JYP, LLC, No. 6:12-BK-00044-KSJ, 2012 WL 13220148, at *11 (Bankr. M.D. Fla. July 24, 2012).

[282] *In re* Hardeman Cnty. Hosp. Dist., 540 B.R. at 241.

In *Hardeman County*, the court highlighted that maintaining the service function of the debtor is central to the purpose of chapter 9 and must be central in evaluating the plan.[283] In confirming the plan, the court concluded that "the Plan reasonably compensates and provides the best recovery for Creditors in the circumstances and the maximum that the Debtor is able to pay while *maintaining its mission of continuing to provide health care services to Hardeman County and its needy inhabitants*."[284]

As part of their objections, the objecting creditors asserted that the debtor should raise taxes to pay more to unsecured creditors. The court rejected that assertion, explaining that, "the Debtor is not in a position to raise taxes because of property values and economic conditions; and the taxpayers of the county are already paying the maximum the *taxpayers will permit*."[285]

Thus, *Hardeman County* illustrates that resident voice, albeit mediated through the county that is proposing the plan, can be heard and have a significant influence in the context of a chapter 9 case. The interests of residents are central to the county's plan, which preserves services for them without increasing taxes. In addition, the residents' interests are central to the court's evaluation and confirmation of the plan.

Although nonprofits share the same public service mission, the question of the applicability of the absolute priority rule is more nuanced for a nonprofit, chapter 11 debtor as compared to a municipal debtor. Although some courts have held that the absolute priority rule is simply not applicable to nonprofits in the same way it is not applicable to public hospital bankruptcy in chapter 9, other courts have taken a more nuanced approach.

*In re Whittaker Memorial Hospital Associatio*n provides one illustration. There, the court confirmed the hospital debtor's plan over the objection of the Secretary of Housing and Urban Development (HUD), finding that the plan did not violate the absolute priority rule by leaving the debtor management group in control without paying HUD's claim in full.[286] The court explained that no distribution was being given to the management group.[287] Rather than giving the management group a favored position over HUD, the court explained, giving control to the management group merely gave them "problems and great anguish ahead."[288] Thus, because the management group

[283] *Id*. ("[T]here is no purpose in confirming a Chapter 9 plan if the municipality will be unable to provide future government services.") (internal quotations omitted).

[284] *Id*. at 242 (emphasis supplied).

[285] *Id*. (emphasis supplied).

[286] *In re* Whittaker Mem'l Hosp. Ass'n, Inc., 149 B.R. 812, 816 (Bankr. E.D. Va. 1993).

[287] *Id*.

[288] *Id*.

received only management control, which the court found to have no value under the circumstances, the absolute priority rule was not violated. In conclusion, focusing on the nonprofit status of the debtor, the court observed that, "[b]eing a Virginia nonstock corporation places it in a unique status apart from private enterprise."[289]

In *In re RHA Stroud, Inc*,[290] however, the court determined that the control the management party would have received would have violated the absolute priority rule.[291] In that case, the debtors were tax-exempt hospital operating entities that were wholly owned by One Cura Wellness, Inc. ("One Cura"), which received a substantial monthly "director's fee" from the hospitals.[292] Because One Cura retained both formal ownership and a continuing economic benefit while creditors remained unpaid, the court concluded that "no legitimate argument" could support allowing One Cura to retain its interests unless creditors were paid in full.[293] *RHA Stroud* analyzes the absolute priority rule functionally, looking past the debtors' nonprofit status and focusing on the economic benefits that flow from continued control. That functional inquiry helps separate mission-protective control, which may indirectly advance resident voice, from insider-protective control, which may use nonprofit form to preserve a private economic stream.

The nonprofit hospital's service mission is also important in the context of a § 363 sale of assets. Section 363(b)(1) of the Bankruptcy Code authorizes the debtor to sell property of the estate outside the ordinary course of business after notice and a hearing.[294]

Section 363(d)(1) provides that the trustee may sell property of a nonprofit corporate debtor pursuant to § 363(b) "only in accordance with nonbankruptcy law applicable to the transfer of property by a debtor that is such a corporation or trust."[295] In *In re HHH Choices Health Plan, LLC*, the court was required to choose between two bids for the nonprofit debtor's assets. One was from Bethel Methodist Home, Inc. ("Bethel"), which proposed to continue

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[289] *Id*.

[290] *In re* RHA Stroud, Inc., No. 20-13482-SAH, 2020 WL 7787034, at *1 (Bankr. W.D. Okla. Dec. 30, 2020).

[291] *Id*.

[292] *Id*. at *2.

[293] *Id*. at *12.

[294] 11 U.S.C. § 363(b)(1).

[295] 11 U.S.C. § 363(d)(1) provides:

The trustee may use, sell, or lease property under subsection (b) or (c) of this section—

(1) in the case of a debtor that is a corporation or trust that is not a moneyed business, commercial corporation, or trust, only in accordance with nonbankruptcy law applicable to the transfer of property by a debtor that is such a corporation or trust.

the nonprofit's continuing care retirement community and health care facilities in the same community. The second was from GF Westchester Holdings, LLC, which offered greater immediate financial compensation to certain residents but did not propose to continue the care facilities in the existing location.

The court examined applicable New York law regarding the sale of nonprofit assets, which was made applicable to the bankruptcy proceeding through § 363(d)(1). Under that law, a sale should be approved if "the terms of the transaction are fair and reasonable to the corporation, and if the purposes of the corporation or the interests of the members will be promoted by the transaction."[296] Applying this standard, the court approved the lower-priced Bethel bid because it was "more consistent with the mission of the company," finding that the Bethel proposal would continue the nonprofit's charitable purpose.[297]

D. State Regulation and Conflicting Voices

As noted, § 363(d)(1) provides that a trustee may use, sell, or lease property of a nonprofit debtor "only in accordance with nonbankruptcy law applicable to the transfer of property by" that nonprofit, and § 541(f) similarly provides that property held by a § 501(c)(3) debtor may be transferred to a non-§ 501(c)(3) entity "only under the same conditions as would apply if the debtor had not filed a case" under the Bankruptcy Code.[298] "The provision is intended to restrict the use, sale or lease of a nonprofit entity's property except in accordance with applicable nonbankruptcy law, so that a nonprofit entity cannot escape supervision by its State's Attorney General, who is given standing to appear and be heard on this issue."[299]

The chapter 11 case of *Verity Health Systems of California*[300] provides an example of how bankruptcy sale authority can limit state oversight of hospital transactions. It also provides another example of elected representatives with conflicting views on how to address distressed hospitals. Before bankruptcy, Verity's predecessor had obtained the California Attorney General's approval for a restructuring transaction involving nonprofit hospital assets, but only subject to conditions designed to preserve community access to care.[301] Those conditions required the hospitals to maintain certain staffing

[296] *In re* HHH Choices Health Plan, LLC, 554 B.R. 697, 701 (2016).
[297] *Id*. at 713.
[298] 11 U.S.C. §§ 363(d)(1), 541(f).
[299] 3 COLLIER ON BANKRUPTCY ¶ 363.04 (16th ed. 2026).
[300] *In re* Verity Health Sys. of Cal., Inc., 598 B.R. 283 (Bankr. C.D. Cal. 2018).
[301] *Id*.

levels, participate in Medi-Cal and Medicare, maintain specified levels of emergency, intensive care, cardiac, and other services, and purported to bind "any and all current and future owners" of the hospitals.[302] The purpose of the conditions was "to ensure the availability and accessibility of health care services to the affected community."[303] The conditions were to remain in effect for up to fifteen years.[304]

Less than three years later, Verity filed chapter 11 and sought to sell hospital assets free and clear of those conditions to Santa Clara County.[305] The bankruptcy court held that the conditions constituted an "interest in property" under § 363(f) because they imposed monetary and operational burdens tied to the hospitals' historical service levels.[306] It further concluded that the conditions functioned as successor-liability obligations not authorized under California law.[307]

Thus, conditions imposed only a few years earlier to preserve community access to care for up to fifteen years were recast as property-related obligations that could be stripped from the hospital assets in a bankruptcy sale. The court treated the conditions not as prospective regulation of behavior but as obligations tied to the hospital's assets and prior operations.[308] Although that conclusion is debatable, a full analysis of it will be left for another day. For now, *Verity* underscores that a chapter 11 filing can call into question the state's ability to exercise its regulatory authority over hospitals within its boundaries.

E. Steward Health Care in Massachusetts: A For-Profit Case Study

Massachusetts's response to the Steward Health Care ("Steward") bankruptcy illustrates both the risks that hospital conversion to a for-profit structure poses to resident voice and the opportunity for a state to assert meaningful influence in a for-profit chapter 11 case. Steward began operating in Massachusetts after Cerberus Capital Management-backed Steward purchased hospitals from the nonprofit Caritas Christi system and later

[302] *Id*. at 288; Response to Debtors' Motion for Entry of (I) an Order (1) Approving Form of Asset Purchase Agreement for Stalking Horse Bidder, and (II) an Order (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances; Memorandum of Points and Authorities in Support Thereof at 5, *In re* Verity Health System of California, Inc., No. 2:18-bk-20151-ER (Bankr. C.D. Cal. Oct. 10, 2018), Dkt. No. 463.

[303] *Id*. at 6.

[304] *Id*. at 8.

[305] *In re* Verity Health Sys. of Cal., Inc., 598 B.R. at 287–88.

[306] *Id*.

[307] *Id*. at 293.

[308] *Id*.

expanded its footprint in the state.[309] According to the Commonwealth, Steward then extracted value from those hospitals through sale-leaseback transactions, investor distributions, and expansion financed by hospital real estate, leaving the hospitals burdened by escalating rent obligations and dependent on corporate-level decisions about which vendors to pay.[310] In that respect, Steward reflects the danger posed by for-profit privatization and private-equity-driven consolidation, as hospitals that are still needed to perform essential public functions are restructured to serve investors, landlords, and lenders, perhaps to the detriment of the communities that depend on them.

When Steward filed chapter 11, Massachusetts did not have the same default control that state or local leaders retain in chapter 9, or the charitable-asset oversight available in nonprofit hospital cases. Rather, it created influence through speed, expertise, and money. The Commonwealth immediately appeared in the bankruptcy, emphasizing that it was both a major payor and the primary regulator responsible for hospital licensure, patient safety, and continuity of care.[311] The Department of Public Health had already begun enhanced monitoring of Steward hospitals after learning of serious financial instability, unpaid vendors, supply shortages, and risks to patient safety.[312] Commissioner Goldstein warned that abrupt closures would disrupt emergency, maternal and newborn, behavioral-health, and other services, and would disproportionately harm low-income, older, MassHealth, Medicare, and uninsured patients.[313]

The Commonwealth then acted not merely as a regulator, but as a crisis manager for hospital access. During the bankruptcy, Massachusetts developed hospital- and region-specific financial support packages to facilitate transfers to new operators, including Medicaid advances and supplemental payments.[314] It committed $115 million in fiscal-year 2025 Medicaid advance payments, $582 million in supplemental payments over three years, and approximately $72 million in transitional operating costs while Steward's financing had

[309] Informational Brief of the Commonwealth of Massachusetts in Support of Responses to the Debtors' Emergency Motions at 3–5, *In re* Steward Health Care System LLC, No. 24-90213 (CML) (Bankr. S.D. Tex. May 7, 2024), ECF No. 61 [hereinafter Mass. Informational Brief].

[310] *Id*. at 2, 8–12.

[311] *Id*. at 1–3.

[312] Declaration of Robert Goldstein ¶¶ 10–16, attached to Mass. Informational Brief, *In re* Steward Health Care System LLC, No. 24-90213 (CML) (Bankr. S.D. Tex. May 7, 2024), ECF No. 61.

[313] *Id*. ¶¶ 17–20.

[314] Mass. Taxpayers Found., *Understanding the Public Costs of the Steward Crisis* 2–4 (Jan. 17, 2024).

collapsed and new operators had not yet taken over.[315] It also used eminent domain to take the St. Elizabeth's campus so Boston Medical Center could continue operating the hospital there.[316]

The result was costly but significant. Two Steward hospitals closed, but five hospital systems, including one with two campuses, transferred to new operators.[317] The Massachusetts Taxpayers Foundation estimated gross state outlays of approximately $791 million and a projected net state cost of approximately $316.3 million after repayment of advances and anticipated federal reimbursement.[318]

Steward offers at least three important and related lessons. First, privatization and private-equity-driven consolidation can leave communities dependent on hospitals whose financial structures make them vulnerable to collapse. Second, even in a for-profit chapter 11 case, a state can preserve resident voice and access to care by acting quickly, combining governmental authority with financial support, and using the bankruptcy process as a forum for coordinated intervention. In chapter 9, public control would have provided a default mechanism for expressing resident interests, while in nonprofit chapter 11, charitable law and mission obligations would have imposed at least some constraints responsive to community needs. In Steward's for-profit chapter 11 case, by contrast, the Commonwealth had to create influence from outside the debtor's governance structure and incur substantial costs. Finally, Steward shows that, when private governance structures fail to account for community interests, the public sector may be forced to reassert resident voice by rescuing essential services after private parties have extracted value and left the operating hospitals financially fragile.

V. Proposed Reforms

Residents of communities served by distressed hospitals often lack formal party status in bankruptcy, leaving their interests to be represented, if at all, by state or local officials. That structure matters because state and local officials serve as a politically accountable conduit for resident voice when bankruptcy threatens access to essential hospital services. The concern is not distrust of bankruptcy judges, who undoubtedly take the consequences of hospital distress for patients, employees, and communities seriously. Rather,

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[315] *Id*. at 2–5.
[316] *Id*. at 4–5.
[317] *Id*. at 1.
[318] *Id*. at 5–6.

the concern is institutional—state and local officials exercise police power and are politically accountable to affected residents, whereas bankruptcy courts, private creditors, and investors are not.

As noted, the degree of protection for resident voice varies by chapter and debtor form. Chapter 9 most effectively preserves state and municipal control. Nonprofit chapter 11 cases may retain some protection through charitable-asset oversight and mission-based obligations. For-profit chapter 11 cases pose the greatest risk to resident representation, as decisions about hospital access and operations may be outside of the control of elected or otherwise politically accountable officials. This Part proposes reforms to protect and enhance the representation of residents in affected communities both before bankruptcy is contemplated, when state and local officials make decisions about hospital ownership and oversight that may shape the consequences of future financial distress, and after a bankruptcy case has commenced, when decisions may affect continued access to care.

A. Proposed Pre-Bankruptcy Reforms

1. Carefully Consider Whether and How to Privatize a Public Hospital

State and local officials should begin by carefully considering whether to privatize a public hospital at all. Although privatization may be perceived as a potential resolution for financial distress, it should also be recognized as a long-term governance choice that may shift authority over access, service lines, and continued operations from politically accountable officials to private boards, investors, lenders, and, if distress follows, a chapter 11 process that may be less protective of resident voice than a chapter 9.

Before approving a transaction that would result in the privatization of ownership or operational control, officials should carefully compare the potential long-term costs and benefits of continued public ownership with those of private nonprofit and for-profit alternatives. This analysis should include a careful assessment of the potential effect of each option on access to essential services, financial stability, political accountability, and resident participation. If officials determine that privatization is appropriate, they should impose conditions to preserve as much public accountability as the transaction can reasonably accommodate.

2. Permit Public Hospitals to File for Bankruptcy

Chapter 9 is the bankruptcy chapter best suited to preserving public control, governmental accountability, and resident voice, all of which are critically important when essential health care services are at stake. Further, as noted above, where chapter 9 is unavailable, quasi-governmental hospital entities may seek relief under chapter 11, a forum less designed to protect public governance, essential services, and resident interests.[319]

As explained, a municipality may file under chapter 9 only if its state specifically authorizes the filing. Prohibiting that option deprives the public entity of a powerful restructuring tool. Chapter 9 also preserves more authority for the debtor and, indirectly, for the state and local officials responsible for the public hospital than chapter 11. Unlike chapter 11, chapter 9 limits interference with governmental powers, property, and revenues, and confirmation standards cannot require payments that would threaten the debtor's public mission. Chapter 11, by contrast, imposes a more creditor-centered system and may sideline elected officials. Additionally, as discussed, chapter 9 can be a unique and powerful tool for the distressed public hospital. Accordingly, states should authorize public and quasi-public hospitals to seek relief under chapter 9. Further, in assessing whether a "blended entity" qualifies as a municipality for purposes of seeking relief in chapter 9, bankruptcy courts should give deference to the state's characterization of those entities.[320]

3. Actively Monitor Hospital Financial Data

State and local leaders should proactively reduce the risk of eventual hospital bankruptcy and better prepare themselves in the event that a local hospital seeks bankruptcy protection. Accordingly, even before signs of financial distress appear, officials should actively monitor the finances of area hospitals. State and local officials often have little or no ongoing knowledge of the financial health of the private hospitals serving the communities within their boundaries. By the time a hospital files for bankruptcy, the institution may already be at risk of closing or reducing services and leaving the surrounding community without reliable access to essential care. At that point, the state's regulatory choices may be constrained by emergency conditions. Ongoing

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[319] *See supra* note 19 and accompanying text. Of course, as discussed above, the chapter 9 filing of a quasi-governmental entity may be challenged on the basis that the entity is not a municipality and, thus, not eligible for relief for that reason.

[320] Coordes, *Public-Private Divide*, *supra* note 19, at 480–81.

financial monitoring would allow officials to identify warning signs, explore options for addressing the problem, and better protect the community's interest in continued access to hospital services.

The Maine Uniform Reporting System, discussed above, provides a useful model for monitoring hospital financial health.[321] As discussed, the system requires a broad array of health care providers and their parent entities to file comprehensive, audited financial information at least annually. It also requires information to be submitted on a standardized form that allows reviewers to compare financial metrics across providers. While the Maine system does not require the responsible state agency to share financial information with municipal officials in the hospital's location, such a requirement could be added to any system based on the Maine model. Doing so would require the state authority to engage local officials in oversight and monitoring, helping establish a collaborative relationship even before any signs of financial distress emerge.

Earlier awareness of impending or actual financial distress should enable state and local officials to consider whether and how to intervene. The state or local actor may choose to provide a loan, tax incentives, or other support to help the hospital stabilize, even if only temporarily. In fact, some states have formal programs to help struggling hospitals. For example, California's Distressed Hospital Loan Program (DHLP), created in 2023, offers interest-free working capital loans to nonprofit and publicly operated financially distressed hospitals.[322] These loans are secured by the hospital's Medi-Cal reimbursements and have a short repayment window.[323] Repayment begins eighteen months after the initial disbursement, and loans must be fully discharged within seventy-two months.[324] In 2025, California established a grant program "to provide grants to [nonprofit and public] hospitals in immediate and significant financial distress to help prevent closure of hospitals."[325]

Programs such as these could serve as a model for other states. Additionally, states could explore extending those programs to provide loans to private hospitals, albeit not likely on the same terms as those loans made to public and nonprofit hospitals. When a sophisticated lender enters a lending relationship with a borrower, it often imposes various negative and affirmative

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[321] *See supra* Part II.B.

[322] Distressed Hospital Funding Programs, Cal. Dep't of Health Care Access & Info., https://hcai.ca.gov/facilities/health-facility-financing/distressed-hospital-loan-program/.

[323] *Id*.

[324] *Id*.

[325] *Id*.

covenants to protect its interests and better ensure repayment. Similarly, a state or local lender could impose reporting covenants, notice requirements, consultation rights, and other similar terms to increase its influence over whether and when a hospital files for bankruptcy.

4. Enhance Transaction Oversight and Approval Authority

In addition to ongoing monitoring of the financial health of hospitals and their health care systems, states should enact a robust oversight system that permits designated state and local actors to receive notice of a proposed transaction, review it, and approve, deny, or approve with conditions. State regulators have long exercised this review and approval authority in the context of material transactions involving nonprofits, ensuring that charitable assets held in trust are not improperly distributed to a for-profit actor. This same type of review and approval process has been implemented in some states to enable them to monitor, control, and protect the provision of health services more broadly.

The relatively recently enacted New Mexico and Oregon systems, discussed above, serve as models for implementing this type of notice-and-approval program. To ensure local voices are represented, any such program could follow Oregon's lead and include a panel of citizens to help set policy.[326] Additionally, the review process for proposed transactions could include forming a community review board composed of community members who will be affected by the transaction.[327]

As noted, a bankruptcy court may decline to give effect to a state-imposed condition or deny a state's attempt to enforce a regulation if that regulation or requirement is construed as having a pecuniary purpose.[328] As such, states should strive to craft conditions primarily as requirements to act or refrain from acting in a given way and tie those conditions expressly and clearly to state or local health policies, while avoiding heavy reliance on conditions that require specific monetary investments or other funding requirements. Additionally, any transaction oversight and approval program should include an expedited process for reviewing and rendering decisions on transactions involving a hospital in financial distress. Meeting this challenge may require additional funding (just as increasing oversight will). However, other financial and personal costs, such as poor health, may be avoided.

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[326] *See supra* Part II.B.
[327] *See id.*
[328] *See supra* Part IV.D.

B. Proposed Post-Bankruptcy Filing Reforms

1. Preserve State and Local Participation in the Bankruptcy Process

State and local representatives should develop an understanding and appreciation of the speed at which bankruptcy courts move, a pace that is both remarkable and often necessary. When a hospital files for bankruptcy, state and local officials should act promptly to preserve their ability to represent affected residents and protect access to care. They should retain experienced bankruptcy counsel and appear early in the case. With experienced counsel, they can more effectively engage in the process, potentially coordinating with the debtor and other stakeholders and monitoring and participating in significant decisions in the proceedings.

One way a governmental actor may choose to participate in the process is by providing debtor-in-possession (DIP) financing to the debtor hospital.[329] A DIP lender can often extract important concessions from the debtor and otherwise greatly influence the outcome of a case.[330]

Outside of bankruptcy, when a state regulator imposes conditions on a proposed transaction, it typically imposes policies on the parties involved to achieve broader policy objectives on behalf of the state and the people it represents. Assuming for the sake of argument that bankruptcy courts can override these policy choices, the courts should do so only with caution.[331]

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[329] Stern, *et al*., *Triage and Treatment*, supra note 126, at 170–71.

[330] Jared A. Ellias & George Triantis, *The Administrative State in Bankruptcy*, 72 DEPAUL L. REV. 323, 344–45 (2023) ("There is no categorical reason why a government agency could not provide DIP loans under agreements that promote policy.").

[331] This caution is supported by Supreme Court precedent. In *BFP v. Resolution Trust Corporation*, the Supreme Court refused to adopt other court-developed methods for assessing the value of foreclosed property and held that, in the context of a mortgage foreclosure, the "'reasonably equivalent value,' for foreclosed property, is the price received at the foreclosure sale, so long as all the requirements of the State's foreclosure law have been complied with." 511 U.S. 531, 545 (1994). In reaching its decision, the Court emphasized that "the States have created diverse networks of judicially and legislatively crafted rules governing the foreclosure process" to achieve what each state regards as the proper balance between the interests of lenders and borrowers. *Id.* at 541–42. A similar principle supports caution here. States have likewise developed varied regulatory frameworks governing health-care transactions, licensing, access, and quality of care, and those frameworks reflect state-level judgments about how best to protect public health and preserve access to essential services. *See also* Midlantic Nat'l Bank v. N.J. Dep't of Env't Prot., 474 U.S. 494, 507 (1986) (recognizing limits on bankruptcy authority where state police-power regulation is reasonably designed to protect public health

2. Establish Avenues for Community Input and Engagement

The residents of a community will have to live with the consequences of the decisions made in a hospital bankruptcy. Given that critical health services are at stake, the parties engaged in a hospital bankruptcy should create avenues for direct community input. Even if that input does not alter the outcome of the proceedings, simply keeping constituents informed and providing them an avenue to engage in the proceedings and be heard can promote confidence in the process, if not agreement with the outcome.

To provide this opportunity, state or local officials could organize a committee of concerned citizens to engage in the proceedings and provide input throughout. This committee could also disseminate information about the proceedings to the community and solicit input from other community members.

The bankruptcy court, for its part, could follow the example set by Judge Rhodes in the City of Detroit bankruptcy case. Judge Rhodes permitted residents of the City of Detroit to appear and be heard at two critical junctures in that case: at the eligibility stage, when the court considered whether the city was eligible to be a debtor in chapter 9, and at the plan confirmation stage, when the court considered whether to confirm the debtor's plan.[332] He later explained that, although the residents' formal legal right to be heard was limited, "the residents' interests were the ultimate goal of the case."[333]

In a hospital case, courts could similarly permit residents to be heard at critical hearings on proposed financing, service reductions, facility closures, asset sales, and plan confirmation. Although it would not guarantee that community views control the outcome, allowing residents to be heard would recognize that residents are not merely observers when critical health services in their community are at stake and would give resident voice a visible place in the process.

Conclusion

The financial condition of hospitals in the United States is increasingly precarious, and that instability is expected to worsen. Recent hospital

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and safety and holding that "a trustee may not abandon property in contravention of a state statute or regulation that is reasonably designed to protect the public health or safety from identified hazards").

[332] Sharon Morioka, *Rhodes Discusses Detroit Bankruptcy*, Univ. of Mich. L. Sch. (Nov. 3, 2025), https://michigan.law.umich.edu/news/rhodes-discusses-detroit-bankruptcy.

[333] *Id*.

bankruptcies and closures reveal the profound consequences that follow when essential health care institutions are allowed to deteriorate. Although hospitals serve public functions, many are now privately owned or controlled in ways that may diminish resident voice and limit public accountability. Private equity investment has contributed to this instability by prioritizing financial returns in a sector where continuity of care, community need, and public health should remain paramount.

When a hospital files for bankruptcy protection, avenues for resident input may vary materially with the hospital's legal form and the bankruptcy chapter under which the case proceeds. These differences provide valuable lessons for state and local officials not only in responding to hospital distress and insolvency but also in deciding whether and on what terms to privatize public hospitals. When hospitals are private, state and local oversight should be designed such that communities are not deprived of meaningful opportunities to influence the future of the health care institutions on which they depend.

This article does not contend that public ownership is always superior. Rather, it contends that privatization is a choice with potentially significant consequences for resident input into decisions affecting access to hospital care, particularly if the hospital later experiences financial distress and files for bankruptcy. Officials should weigh those consequences and preserve community input when feasible. When a hospital does enter bankruptcy, state and local officials should participate actively, particularly when essential services are at risk. Further, bankruptcy courts, acting within their authority and guided by applicable state law, should ensure that the interests and perspectives of affected communities are meaningfully considered in decisions concerning facility closures, service reductions, and other actions that may affect access to care.

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