Using the Double Lockbox to Navigate Healthcare Asset-Based Lending

By Robert L. Harris

Healthcare is a unique industry with very specialized rules given the prevalence of government payors. Lenders entering this industry must be very cognizant of rules and regulations governing the assignment of governmental healthcare receivables. A carefully structured double lockbox agreement can comply with recent judicial and CMS-guidance regarding the federal reassignment provisions.

Healthcare expenditures have increased rapidly over the past several years and threaten to skyrocket in the next few decades. The aging of the baby boomers, outdated facilities and new technology are factoring driving this increase in spending. In 2002, the Healthcare Finance Forum estimated that healthcare expenditures would hit $3.6 trillion per annum by 2050, constituting approximately 17% of gross domestic product by 2011. Against this backdrop, the healthcare industry’s need for capital is rapidly expanding.

Many banks and healthcare specialty lenders currently serve this market. However, in order to accommodate this huge demand for capital, many new lenders, private equity and hedge funds have begun to extend financing to healthcare companies. These entities have brought underwriting, legal and collateral structures with them from other industries. Healthcare, however, given the high prevalence of government reimbursement, is unique. Lenders unaccustomed to lending in the healthcare industry need to be aware of certain traps for the unwary in structuring the security package, which can undermine the value of a lender’s collateral pool and increase credit risk.

Asset-Based Lending In Healthcare

One of the most common forms of financing in the healthcare industry is that of asset-based financing. Unlike asset-based financing in many other industries — where there is a variety of inventory, equipment and other property that can be easily valued and sold off upon an event of default — healthcare asset-based financing frequently boils down to accounts receivable financing. In healthcare, there is often not much of a market for medical inventory; healthcare equipment is often too specialized to be easily resold, and healthcare real estate often consists of single-purpose facilities, which state and local authorities are often unwilling to shut down given its public health purpose and provision of services to the community.

Healthcare specialty lenders generally structure their asset-based facilities based on the value of “eligible accounts.” Lenders will generally lend on billed receivables outstanding less than a certain number of days, and unbilled services that are billed within a certain time period from the date of service. Often, lenders will exclude accounts from certain obligors, which have a history of slow pay and self-pay.

In addition, lenders will apply an advance rate to the pool of receivables. Advance rates are set based on the lender’s experience with collection in a given niche or sector of the industry. The lender will often also apply a liquidity factor, which may be adjusted during the life of the facility in the lender’s discretion. This permits the lender to respond to any prospective changes in reimbursement rates, the financial health of third-party payors and other contingencies unanticipated at the time of the loan.

Federal Reassignment Provisions

The Social Security Amendments of 1972 expressly restricted the assignment of healthcare payments made under the Medicare and Medicaid programs by providers. The legislative history associated with the enactment of the Social Security Amendments of 1972 revealed that Congress was concerned with abuses of the federal healthcare reimbursement system due to the factoring of healthcare receivables. At the time, factors would provide financing to healthcare providers by purchasing the provider’s receivables and then submitting claims to either federal or state government entities for payment. Often, the factor would submit the claim in its own name. This led to numerous abuses, including the preparation of incorrect, inflated or double claims. In addition, this created administrative nightmares for Medicare and Medicaid as reimbursement was being claimed by and paid to entities entirely different from the provider. According to House Report No. 92-231 (1972), factoring had resulted in overpayments by governmental entities in excess of $1 million.

In 42 USC §1395(g) and its implementing federal regulation 42 CFR §424.71 no healthcare payments under Medicare Part A for a service to an individual may be made to any party other than a healthcare provider, except for (i) Payment to a government agency, ii) Payment established by or pursuant to the order of a court of competent jurisdiction or iii) Payment to a billing and collection agent of the provider pursuant to an agency agreement so long as the compensation to be paid to the agent is unrelated (directly or indirectly) to the amount of payments collected, and the agent acts solely on behalf of the provider.

Medicare Part B treats payments similarly. In 42 USC §1395u(b)(6) it is stated that "no payment under this part for a service provided to any individual shall be made to any other person than such individual or the physician or other person who provided the service." Congress, in 42 USC §1396a(a)(32), mandated that a state plan for medical assistance (i.e., Medicaid) must apply similar limitations, and 42 USC §1396a(a)(32) states in part that "no payment under the plan for any care or service provided to an individual shall be made to any other person than such individual or the person or institution providing such care or service," except for an assignment to a government agency, pursuant to the order of a court of competent jurisdiction or to a collection agent pursuant to a permissible agency agreement.

In 1985, the Fifth Circuit in In re Missionary Baptist Foundation of America, Inc. (796 F.2d 752 (5th Cir. 1986)), held that a creditor could collateralize its loan to a nursing home operator by obtaining a security interest in the operator’s accounts receivable and receiving assignment of the operator’s accounts receivable under the Medicaid program. The Fifth Circuit supported this holding by noting that none of the federal statutes (and state Medicaid statutes at issue) explicitly prohibit providers from granting a security interest in their receivables; it only restricts the governmental healthcare program from making payments to anyone other than the provider of services. In addition, the Fifth Circuit noted that prohibiting healthcare providers from granting security interests in their receivables would severely shake the confidence of healthcare lenders and could undermine lenders’ willingness to finance healthcare providers, thereby.
undermining the federal and state purpose of providing medical assistance to the needy.

Since 1985, there have been a number of court cases and administrative guidance from the Centers for Medicare and Medicaid Services (CMS) and its predecessor entities, which have expressly recognized that providers may pledge their accounts receivable to lenders. In 2004, the Seventh Circuit in DFS Secured Healthcare Receivables Trust (384 F.3d 338 (7th Cir. 2004)) held that there is nothing in the reassignment provisions that prohibits the assignment of Medicare or Medicaid receivables by a provider to a non-provider. At most, the court recognized that the federal reassignment provisions only require that the government make payment to the provider, but that the statutes do not prohibit a third-party financier from receiving Medicare funds if they first flow through the provider.

Most recently, CMS issued Publication 100-04 (June 25, 2004), which updated its Medicare Claims Processing Manual. In Publication 100-04, CMS explicitly recognized that Medicare payments might be sent to a bank (not the provider) so long as they are made in the name of the provider and certain other requirements are met. These requirements include that i.) The bank account to which payment is made must be solely in the name of the provider and ii.) Only the provider may issue instructions on the account. CMS also expressly recognized that the provider's bank account could be swept to the account of the provider's “financing entity” so long as the provider supplied the standing transfer instructions to the account bank, and that provider retains the right to rescind such transfer instructions, “notwithstanding the fact that it is a breach of the provider/supplier’s agreement with the financing entity.” In this publication, CMS implicitly recognized the long-standing double lockbox structure as complying with the reassignment provisions.

The Double Lockbox
In order to comply with the federal reassignment provisions, which require that government payments get made directly to a provider and that the provider maintain control over the account receiving Medicare and Medicaid payments, healthcare specialty lenders have developed a collateral structure, called the double lockbox. The double lockbox provides the lender sufficient access to the governmental accounts receivables to provide credit support, while complying with the letter and spirit of the federal reassignment provisions.

In the security agreement, the provider will grant a security interest in its accounts receivable to the lender. This grant and the accompanying filing of a financing statement in the appropriate filing office will perfect the lender’s security interest in the accounts receivable. In addition, lenders generally favor gaining control over deposit accounts since control is the only way to perfect a security interest in a deposit account under Article 9 of the Uniform Commercial Code. However, the provider cannot grant control over the depository account, which will hold the governmental healthcare receivables without violating the federal reassignment provisions. Healthcare lenders have developed the double lockbox structure to address this risk.

In establishing a double lockbox structure, the healthcare provider will establish an account with a depository bank (Governmental Depository Account) to handle the governmental receivables. The Governmental Depository Account must be solely in the provider’s name. Only the provider may have the right to issue instructions on that account. The lender will establish a second account with another bank (the Concentration Account), which will be in the lender’s name and under its sole dominion and control. The provider will issue standing transfer instructions to the depository bank, to transfer any funds in the Governmental Depository Account to the Concentration Account. The depository bank will generally be required to execute the standing transfer, or sweep, to the Concentration Account daily.

Healthcare lenders will require the provider to treat non-governmental receivables as a traditional asset-based lender would. Providers will be required to have commercial obligors, such as insurance companies, health plans and individuals (self-pay), send payments to a separate account (the Commercial Depository Account) over which the lender has control. In some transactions, the lender may even require the Commercial Depository Account to be in the lender’s name and subject exclusively to the lender’s instruction. The lender often requires that the depository bank sweep the proceeds in the Commercial Depository Bank to the Concentration Account. This ensures that the lender remains perfected and maintains control over the accounts receivable from commercial payors.

Healthcare lenders are generally comfortable with this approach because it only introduces the discrete risk of diversion of accounts constituting one day of governmental receivables. The loan agreement will contain covenants prohibiting the provider from altering or changing the standing transfer instructions, and any such change will constitute an event of default under the loan agreement. The depository agreement will also generally require the depository bank to provide notice to the lender if the provider makes any changes to the commercial account or the standing transfer instructions. An event of default permits the lender to restrict access to additional advances under the loan agreement or, in extreme cases, foreclose and accelerate the loan if the provider has diverted payments on the receivables.

Conclusion
Healthcare is a unique industry with very specialized rules given the prevalence of government payors, such as Medicare and Medicaid. Lenders entering this industry must be very cognizant of rules and regulations governing the assignment of governmental healthcare receivables. Fortunately, a carefully structured double lockbox agreement can comply with recent judicial and CMS-guidance regarding the federal reassignment provisions. With advice from a healthcare finance specialist, lenders should feel more confident than ever in the value of governmental healthcare receivables pledged to them as collateral.

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