Are Insurance Plans Encouraging Unnecessary Bankruptcy Filings?

Up to a point, the following story is unremarkable. A patient visits his local healthcare provider for emergency services, in this case a hospital which is not contracted with his insurance plan. He is admitted, treated, and discharged. As part of his admission forms he assigns his insurance benefits to the provider. The provider bills the insurance plan, which approves some of the charges. However, instead of paying the healthcare provider who performed the services, far too often the insurance plan pays the patient. In paying the patient, the insurance plan ignores the instruction of its own member. The patient is now in possession of a check for tens of thousands of dollars. What happens next is occurring with increasing frequency and highlights the problems with the insurance plan's practices.

The patient does not forward the payment to the hospital but instead retains the funds. The patient is of course aware that he received valuable medical services and that he assigned his insurance benefits to the provider. He is also aware from his explanation of benefits that his insurance plan has approved payment for the charges. When faced with unpaid bills in one hand, and a check from the insurance company for tens of thousands of dollars in the other hand, many patients are choosing to keep the check.

There are more than 1.5 million bankruptcy filings each year. The majority are chapter 7 cases where nothing is paid to creditors. Unpaid medical bills play a role in most chapter 7 cases and in one poll 28% of respondents blamed their bankruptcy filing directly on their medical bills. Insurance plans are not helping themselves, their members, or providers, when they continue to pay patients directly for services provided by someone else.

When the patient spends the benefit money and then files bankruptcy, the provider can sue. Bankruptcy Code section 523(a)(6) permits a creditor to sue for "willful and malicious injury by the debtor to another entity or to the property of another entity." In other words, a successful lawsuit will result in a judgment in favor of the provider which will survive as though there had been no bankruptcy. In each of the following court cases the debtor signed an assignment of benefits, the insurance plan paid the patient, and the court ruled in favor of the provider.

In R.T. Vagley, M.D. v. Lavitsky (In re Lavitsky), 11 B.R. 570 (Bankr. W.D. Pa. 1981) the debtor delivered the first benefit check to the surgeon but retained subsequent checks. The court found that: "At no point did [the debtor] have a claim on these checks. The checks either belonged to the physician or to Blue Shield; they were not for the personal use of [the debtor]." The court held that "a deliberate and intentional conversion occurred when [the debtor] personally used the funds without the plaintiff's knowledge or consent."

I*n Richmond Metropolitan Hospital v. Hazelwood (In re Hazelwood)*, 43 B.R. 208 (Bankr. E.D. Va. 1984) the debtor attempted to revoke the assignment. The court held the assignment was irrevocable and the debtor had no right to the proceeds. The hospital showed it had an "immediate and superior right to possession of the allegedly converted material." The court found there was "no doubt that [the debtor's] assertion of dominance and control over the proceeds of the insurance check was intentional and deliberate." The court found no justification for the debtor's revocation of the assignment. "Such a revocation was unlawful and, thus, malice can be properly implied."

In Albin D.P.M. v. Hopkins (In re Hopkins), 65 B.R. 967 (Bankr. N.D. Ill. 1986) the debtor executed an assignment of benefits but insurance plan issued checks directly to the debtor. The debtor used the checks to make mortgage payments. The debtor later sent a note apologizing for retaining the checks and included a partial payment. The court found that a valid assignment existed whereby the assignee acquired all the interest of the assignor. The court also found that the insurance checks were the property of the hospital. The court held that the conduct was willful because the debtor cashed the checks, an intentional act that deprived the creditor of its funds.

In Baton Rouge Neonatal Associates v. Ward (In re Ward), 2003 Bankr. LEXIS 2135 (Bankr. M.D. La. 2003) the court did not find it credible that the debtor did not know why the insurance plan was sending checks to her. The court held that "the assignments vested title in the transferees, including [the creditor], who received the 'present and immediate right' to the insurance benefits." The debtor used the money with the knowledge that she would be unable to repay the provider and that it was substantially certain it would suffer a loss, which rendered the debt subject to section 523(a)(6).

Healthcare providers faced with this situation should not despair. Until such time that health plans comply with the wishes of their members by paying providers directly, providers can utilize the assistance of counsel to pursue delinquent patients.■

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