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The Poor Get Poorer: The Fate of Distressed Hospitals Under the Affordable Care Act

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Synopsis

Distressed hospitals in America operate on small or non-existent profit margins.[3] For many of those hospitals, the federal Medicare program and the individual States' Medicaid programs are the largest payors. While the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") was designed in part to increase the number of insured nationwide, the result of which should be positive for hospitals, any cause for celebration must first address the cost containment provisions in the Affordable Care Act that create new concerns for financially distressed hospitals. Included among the multitude of provisions in the Affordable Care Act are an immediate 1% cut in Medicare revenue, phased in reductions in disproportionate share payments to hospitals, future, permanent penalties of up to 1% of Medicare payments for hospitals which perform poorly under the Hospital Value Based Purchasing Program, and additional penalties for hospitals with unacceptable rates of re-admission or too many hospital acquired conditions rates.[4] Together these cuts create a daunting challenge for the many financially distressed hospitals in America that simply lack the resources to

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establish an infrastructure designed to treat Medicare patients in this era of change.

Background

Medicare is the federal program that provides health care coverage to individuals aged 65 or older. Medicaid offers similar access for medical services on a state level for qualifying individuals, many of whom are poor. Medicaid covers 69 million people.[5] By 2020, under the Affordable Care Act the number of Medicaid beneficiaries is likely to increase to 93 million.[6] Combined, Medicare and Medicaid pay for more than half of the annual hospital bills in America.

The level at which Medicare and Medicaid reimburse is dictated by legislation and policy, not the market. By most statistics these programs fail to reimburse hospitals even what it costs the hospitals to provide services to the programs' beneficiaries, let alone make a profit. In fact, Medicaid only pays about 88% of the actual costs of treating Medicaid patients, and, while Medicare rates are historically better, Medicare only pays for about 78% of a hospital's services.[7] In 2010, the estimated difference between the hospital industry's cost of care to Medicare and Medicaid beneficiaries and the industry's reimbursement was over $27 billion.[8] It has been estimated that Medicare profit margins were approximately minus 4.5 percent (-4.5 %) for all hospitals in 2010, and will decline to minus 7 percent (-7%) in 2012.[9] Certain hospitals are particularly vulnerable to Medicare's and Medicaid's payment inequities. For example, more than half of the urban safety-net hospitals in America lost money in 2009 and generally their operating margin was minus .06 percent (—0.06%). However, it is estimated that the Affordable Care Act will force an additional 10% of the urban safety-net hospitals to lose money and reduce their median operating margin to minus 2.02 percent (-2.02%).[10]

Distressed hospitals are those operating with EBITDA of 0% or less annually. This is a significant percentage of America's hospitals, as more than one-third of the nation's hospitals had a negative operating profit margin in 2012 (22.4% of California's hospitals operated at a loss in 2010), and even with other resources the number of hospitals with a negative total margin exceeded one-quarter of all hospitals in America.[11]

A significant percentage of those hospitals rely on Medicare and Medicaid payments. Because so many hospitals struggle with razor-thin profit margins, downward fluctuations in Medicare reimbursement will have a significant impact on profitability. For example, California's 373 hospitals had an average operating profit margin of 2.63% in 2012[12], while more than a third of Massachusetts's hospitals lost money in 2011 (overall Massachusetts's 65 acute care hospitals had only a 2.1% profit margin).[13] And many states are doing worse—New Jersey's hospitals had only a 0.3% profit margin in 2011.[14]

Because so much of the hospital industry relies on Medicare and Medicaid revenue, any reductions in reimbursement can have a significant negative impact on the financing of distressed hospitals. Unfortunately, the Affordable Care Act provides for approximately $155 billion in cuts in hospital payments over the coming decade.[15] While this may be small in comparison to Medicare's annual spending of $556 billion, of which more than $125 billion are related to hospital inpatient costs,[16] cuts to already cash strapped facilities may deprive them of funds for capital improvements, maintenance, acquisition or even improvement

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of equipment and technology, staffing and the training of staff, and debt service.

Disproportionate Share Cuts

Under the Emergency Medical Treatment and Labor Act ("EMTALA") hospitals must provide medical care to patients who present at their emergency rooms, without regard to ability to pay or their immigration status.[17] And for many reasons, Americans rely heavily on hospital emergency departments. In 2011, there were over 129 million emergency department visits, a 22% increase over the past decade.[18] Hospitals provided a corresponding $41.1 billion in uncompensated care in 2011, including "bad debt" (services for which hospitals expected to be paid but were not paid) and charity care (services for which the hospital never expected to be paid and were not paid, usually because the patient could not pay).[19]

Because the Medicare program recognizes that the financial burden of this obligation to treat uninsured patients falls disproportionately on certain hospitals in mostly poor, urban and rural neighborhoods, it provides supplemental payments to those hospitals to compensate them. These payments, called Disproportionate Share ("DSH") payments, total over $20 billion annually.[20] Because the Affordable Care Act presumes that the number of uninsured will significantly decline under its requirements, the Affordable Care Act reduces those payments by as much as 75% beginning in October 2013.[21] Unfortunately, a significant percentage of uninsured are also in the United States illegally—and therefore will not be eligible for coverage under the Affordable Care Act.[22] The net result—the Affordable Care Act will reduce these payments but most of the uncompensated care for which it was supposed to cover will continue.

These cuts will be significant, because "safety net" hospitals treat a significant percentage of uninsurable patients. For example, a hospital in Brooklyn, New York, estimated that 20% of its patients were uninsurable, while city-wide New York's Health and Hospitals Corporations, which runs New York City's public hospitals, estimates that 40% of its 480,000 uninsured patients in 2011 were uninsurable.[23] Hospitals in New York State generally receive $2.84 billion annually in DSH payments, but because of the assumptions in the Affordable Care Act, those payments start to be reduced in 2014 and will be reduced by more than half by 2019. Because the Supreme Court has ruled unconstitutional the Affordable Care Act's requirement that states expand their Medicaid coverage and because undocumented residents will always be ineligible for coverage, the cuts will not be offset by additional coverage of individuals.[24]

Patient Satisfaction Surveys

One of the more difficult financial issues facing hospitals under the Affordable Care Act is possible reductions in compensation due to poor results on patient satisfaction surveys. Section 3001 of the Affordable Care Act creates incentives for hospitals to think in terms of performance (i.e., quality) rather than number of procedures performed or patients treated (i.e., quantity), let alone the cost involved in providing such care (i.e., expenses). Since the 1980s, Medicare has reimbursed hospitals for inpatient procedures by using a predetermined amount per discharge, dependent on many factors, including the particular clinical category and a geographically indexed labor cost component (commonly referred to as Diagnostic Referral Groups, or "DRGS"). As of 2008, Medicare modified the DRGS system, and pays rates by clinically categorizing patient cases in 749 different Medicare severity-diagnosis related groups ("MS-DRGS") as well as whether a patient has a complication or co-morbidity.[25] For out-patient procedures, Medicare pays hospitals a predetermined amount for each of approximately 850 ambulatory payment classification groups.[26]

However, the Affordable Care Act automatically reduces DRGS payments to over "3,000 hospitals by 1 percent to create a pool of funds from which value-based (i.e., performance based) incentive payments will be made."[27] This Hospital Value Based Purchasing Program ("VBP Program") requires that hospitals measure performance in clinical areas while monitoring patient satisfaction in others through Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPs") surveys, among others. These surveys obtain feedback on how a patient perceives the hospital's services and whether the patient would recommend the hospital to a friend or family member. While these surveys make up only 30% of the Total Performance Score under the VBP Program, the other 70% comes from the ways in which a hospital scores on its Clinical Process of Care criteria, including those in such areas as acute myocardial infarction, heart failure, pneumonia and surgical care improvement. These patient satisfaction surveys will typically be conducted

by private companies either by telephone or mail, and will ask patients to rank the hospital in eight separate areas of their experience (including communication with nurses and doctors, pain management and cleanliness). Medicare will withhold one percent (1%) of its reimbursements to hospitals in 2012 (rising to two percent (2%) in 2016), but hospitals that perform poorly will not be entitled to any of the bonus pools created by the holdback of the one percent. For hospitals that treat primarily poor and elderly patients and lack the resources to invest in infrastructure, obtaining high marks under the VBP Program may prove elusive, if not impossible. For example, financially distressed hospitals frequently are forced to curtail capital improvements, leading to a deteriorating physical plant. Patients treated in an older, less attractive facility may rank the quality of care as lower, even if it is not. Thus, financially distressed hospitals may have a hard time obtaining scores that would result in additional funding under the bonus pool, and may even face a permanent reduction without much hope of participating in the bonus pool.

This reduction especially affects urban safety-net hospitals[28] which treat more seriously ill, low-income patients who are more likely to respond with negative comments on the VBP Program. In addition, urban safety-net hospitals believe "[b]oth the survey's questions and manner in which they are weighted appear to be biased against large urban hospitals."[29] Of course, these are the hospitals most in need of these funds.

Re-Admission Penalties

Another potentially significant cut in Medicare's payments to hospitals relates to readmissions of patients.[30] Almost 20% of Medicare patients—about 2 million patients per year—are readmitted to a hospital within a month.[31] These readmissions cost the Medicare program more than $17 billion annually.[32] In an effort to reduce this cost by compelling hospitals to care about what happens to their patients even after they are discharged, Medicare, under the Affordable Care Act, now penalizes hospitals which have unacceptable readmission rates. In October 2012, Medicare imposed these cuts, reducing payments to 2,217 hospitals nationwide because of unacceptable readmission rates.[33] Three hundred and seven (307) of those hospitals were cut 1% of their patient reimbursements for a year, the maximum penalty.[34] This maximum penalty is set to rise to 2% in October 2013 and to 3% in October 2015.[35] Additionally, while currently Medicare only considers readmissions for heart attack, heart failure and pneumonia patients (although Medicare considers a readmission against the hospital even if it is unrelated to the reason for the original admission), in the future Medicare will expand the list of conditions which will result in penalties for readmissions.[36]

However, factors over which hospitals have no control greatly influence readmission rates. For example, many of the Medicare patients served by private urban safety net hospitals "have only had sporadic contact with the health care system … so they have numerous medical problems beyond those" which originally caused them to be admitted.[37] And these patients frequently do not comply with discharge instructions.[38] The result? These hospitals are going to be punished for poor readmission rates even though those rates are most likely "tied to socioeconomic factors and access problems than they are to a hospital's performance."[39]

Conclusion

At least one-quarter to one-third of the hospitals in the United States operate with little or no profit margin and those hospitals are heavily dependent on Medicare and Medicaid reimbursements. On one level, the Affordable Care Act makes those hospitals more likely to receive reimbursement by increasing the number of insured patients, and correspondingly, decreasing the number of uninsured patients. However, significant cuts in Medicare and Medicaid reimbursement rates because of poor patient surveys, high readmission rates or reductions in DSH payments will have significantly negative financial impacts on distressed hospitals in the future.

NOTES

1. **Sam Maizel** is a partner with Pachulski Stang Ziehl & Jones LLP, the nation's largest restructuring and insolvency law firm. His practice includes advising and representing businesses on bankruptcy matters and financial restructuring in and out of court, with an emphasis on the healthcare industry. Before joining Pachulski Stang, he represented the federal government in bankruptcy, district and appellate courts nationwide as a trial attorney in the U.S. Department of Justice's Commercial Litigation Branch. He has also served in the U.S. Army's Judge Advocate General's Corps, including service in Operation Desert Shield/Desert Storm, for which he was awarded the Bronze Star Medal. He has lectured extensively, is widely published, and been interviewed on televi-

sion and radio on bankruptcy topics. Additional information can be found at www.pszjlaw.com.

2. **Craig Garner** is an attorney and health care consultant, specializing in issues surrounding modern American health care and the ways in which it should be managed in its current climate of reform. His law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. He is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act. Between 2002 and 2011, he was the Chief Executive Officer at Coast Plaza Hospital in Norwalk, CA. Additional information can be found at http://www.craiggarner.com.

3. See, e.g., 42 U.S.C.A. § 1395ww; Marianna Kiselev, *Hospitals in Distress: How the Economy has Affected Financing of Health Care*, Ill. Bus. Law J., 21:34, (Mar. 16, 2010); available at http://www.law.illinois.edu/bljournal/post/2010/03/16/hospitals-in-distress-how-the-economy-has-affected-financing-of-health-care.aspx%20(1/5/2013). ("A healthy operating margin for a hospital is 3 to 5 percent…[but] a recent study of hospitals in 28 states indicates that more than half of them reported negative operating margins;" in other words, "the hospitals operating revenue is less than the operating expenses.").

4. For a comprehensive discussion of the potential impact of the Affordable Care Act on the healthcare sector see David Gruber, *Getting Much Closer to the Cost Precipice*, Alvarez & Marsal Healthcare Industry Group (2012) (copies can be obtained by contacting Guy Sansone, the Managing Director of AMHIG). For a detailed discussion of the potential impact of the Affordable Care Act on urban safety-net hospitals, see National Association of Urban Hospitals, *The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals* (Sept. 2012), available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

5. Congressional Budget Office, Data released February 2011. Spending and Enrollment Details for CBO's March 2011 Baseline Medicaid, available at http://cbo.gov/budget/factsheet/2011b/medicaid.pdf.

6. Congressional Budget Office, Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline.

7. Marianna Kiselev, Hospitals in Distress: How the Economy has Affected Financing of Health Care, Ill. Bus. Law J., 21:34, (Mar. 16, 2010), available at http://www.law.illinois.edu/bljournal/post/2010/03/16/hospitals-in-distress-how-the-economy-has-affected-financing-of-health-care.aspx (Last visited 1/5/2013).

8. Am. Hosp. Ass'n, Prepared to Care, at 17 (Nov. 2012), available at http://www.aha.org. Some sources report the deficiency as much as $36 billion in 2009. See Quorum Health Resources, Back From the Brink, at 3; see also Avalere Health Analysis of American Hospital Association Annual Survey Data, 2010.

9. Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy, at 54 (Mar. 2012), available at www.medpac.gov/documents/Mar12_EntireReport.pdf.

10. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 6, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

11. Quorum Health Resources, Back From the Brink: How Hospitals in Distress Can Survive and Thrive, at 2 (May 2012), available at intensiveresources.com/content/files/white-papers/Back_from_the_Brink_-_May_2012.pdf. The operating margin is probably the most commonly used financial ratio to measure a hospital's financial performance (it compares total operating revenue against total operating expenses). However, total margin may more accurately represent a hospital's financial health, in that it compares a hospital's net income against its total operating revenue. In California, for example, such revenue may include disproportionate share payments, distressed hospital payments and quality assurance fees (a form of Medi-Cal supplemental revenue). For many California hospitals, these non-operating revenues from various government sources can far exceed total operating profits. Because total margin also includes investment income, it can be quite volatile.

12. Tom Kisken, Some Local Hospitals Struggle for Profit; Others Hit Double Digits, Ventura County Star, Aug. 18, 2012, available at http://m.vcstar.com/news/2012/aug/18/some-local-hospitals-struggle-for-profit-others/ (Last visited 1/5/2013).

13. Robert Weisman, With profits down, future of Mass. hospitals questioned, The Boston Globe, Sept. 8, 2012, available at http://www.bostonglobe.com/business/2012/09/07/with-profitability-down-questions-are-being-raised-about-future-massachusetts-hospitals/sp1cv8kAGaKZrW7LZbmDUM/story.html (Last visited 12/18/2012).

14. Dan Goldberg, N.J. hospitals saw smallest profit margin in 3 years in 2012, Newark Star Ledger, Dec. 21, 2012, available at http://blog.nj.com/ledgerupdates_impact/print.html?entry=/2012/12/nj_hospitals_saw_smallest_prof.html (Last visited 1/5/2013).

15. Robert Pear and Reed Abelson, Hospitals Fear They'll Bear Brunt of Medicare Cuts, N.Y. Times, Dec. 18, 2012, available at http://www.nytimes.com/2012/12/19/business/medicare-cuts-how-deep-and-where.html.

16. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospi-

tals-face-pressuure-from-medicare-to-avert-readmissions.html.

17. 42 U.S.C.A. § 1395dd; see also Laura D. Herrner, The Scapegoat: EMTALA and Emergency Department Overcrowding, 14 J.L. & Pol'y 695 (2006).

18. Am. Hosp. Ass'n, Prepared To Care, Nov. 2012, available at http://www.aha.org.

19. Am. Hosp. Ass'n, AHA issues 2011 data on hospitals' uncompensated care, Jan. 4, 2013, available at http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=ANANEWS/AHANNewsNowArticle/data/ann_010413)uncompensated&domain+AHANEWS (Last visited 1/5/2013).

20. Nina Bernstein, Hospitals Fear Cuts in Aid for Care to Illegal Immigrants, N.Y. Times, July 26, 2012, available at http://www.nytimes.com/2012/07/27/nyregion/affordable-care-act-reduces-a-fund-for-the-uninsured.html (Last visited 12/18/2012).

21. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 22, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

22. Nina Bernstein, Hospitals Fear Cuts in Aid for Care to Illegal Immigrants, N.Y. Times, July 26, 2012, available at http://www.nytimes.com/2012/07/27/nyregion/affordable-care-act-reduces-a-fund-for-the-uninsured.html.

23. Nina Bernstein, Hospitals Fear Cuts in Aid for Care to Illegal Immigrants, N.Y. Times, July 26, 2012, available at http://www.nytimes.com/2012/07/27/nyregion/affordable-care-act-reduces-a-fund-for-the-uninsured.html. Similarly, in California there are estimates that in some areas of central California 40% of residents were illegal immigrant farm-workers.

24. Nat'll Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 3, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

25. A more detailed description of the acute inpatient payment system used by Medicare can be found at http://www.medpac.gov/documents/MedPac _Payment_Basics_11_hospital.pdf.

26. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, at 50 (Mar. 2012), available at http://www.medpac.gov/documents/Mar12_EntireReport.pdf. A more detailed description of the outpatient payment system can be found at: http://www.medpac.gov/documents/MedPac_Payment_Basics_11_OPD.pdf.

27. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, at 54, available at www.medpac.gov/documents/Mar12_EntireReport.pdf.

28. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 4-5, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

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30. Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy, at 54, available at www.medpac.gov/documents/Mar12_EntireReport.pdf.

31. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressuure-from-medicare-to-avert-readmission.html.

32. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressuure-from-medicare-to-avert-readmission.html.

33. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressuure-from-medicare-to-avert-readmission.html.

34. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressuure-from-medicare-to-avert-readmission.html.

35. Jordan Rau, Hospitals Face Pressure to Avert Readmissions, N.Y. Times, Nov. 26, 2012, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressuure-from-medicare-to-avert-readmission.html. Sources have estimated a 2% reduction will cost hospitals approximately $41 billion over the next decade.

36. Quorum Health Resources, Back From the Brink: How Hospitals in Distress Can Survive and Thrive, at 4, available at intensiveresources.com/content/files/white-papers/Back_from_the_Brink_-_May_2012.pdf.

37. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 4, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

38. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 4, available at www.nauh.org/com-

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39. Nat'l Ass'n of Urban Hosps., The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals, at 4, available at www.nauh.org/component/option,com_rubberdoc/format,raw./id,115/view,doc/.

DEFALCATION: INNOCENT ACT OR RECKLESSNESS?

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Among the exceptions to discharge in the Bankruptcy Code, 11 U.S.C.A. § 523(a)(4) provides that debts arising from "fraud or defalcation while acting in a fiduciary capacity, embezzlement or larceny" are not dischargeable in bankruptcy. "Defalcation" is not defined in the Code. Perhaps not surprisingly, the circuit courts have fundamentally disagreed about what constitutes defalcation. Does an innocent act qualify as defalcation, or does it require a showing of something more—for example, willful neglect or recklessness? The answer to that question is crucial for debtors and bankruptcy professionals. If defalcation includes innocent acts by a fiduciary, a significantly larger class of debts will be declared nondischargeable under § 523(a)(4). This would offend the long-established objective of the Bankruptcy Code to provide honest debtors a fresh start. The Supreme Court of the United States will take up the issue in a case from the United States Court of Appeals for the Eleventh Circuit.[1]

The Fifth, Sixth and Seventh Circuits have held that defalcation requires a showing, at least, of recklessness by the fiduciary.[2] The Fourth, Eighth and Ninth Circuits have held that an innocent act by a fiduciary can be a defalcation.[3] The First and Second Circuits have held that defalcation requires extreme recklessness by the fiduciary.[4] In *Bullock v. BankChampaign, N.A. (In re Bullock),* the Eleventh Circuit aligned itself with the Fifth, Sixth and Seventh Circuits, and held that defalcation requires a breach of fiduciary duty that can be characterized as objectively reckless.[5] The Supreme Court granted *certiorari* in *Bullock*, and hopefully will clarify what does and does not rise to the level of defalcation for purposes of dischargeability. The resolution of this issue will impact all bankruptcy cases in which the debtor has liability stemming from fiduciary conduct.

Bullock v. BankChampaign, N.A.

In 1978, Randy Curtis Bullock became the trustee of his father's living trust, the sole asset of which was a life insurance policy on his father's life. Bullock and his four siblings were the beneficiaries. Bullock, as trustee, was permitted to withdraw funds from the trust in two circumstances: to pay the life insurance premiums, and at the request of a beneficiary.[6] Bullock made three loans from the trust. The first loan, in the amount of $117,545.96, was made in 1981 to Bullock's mother, at the request of his father. The funds were to repay a debt that Bullock's mother owed to his father's business. The second loan was made in 1984, in the amount of $80,257.04, to Bullock and his mother to buy certificates of deposit, which were then used to partially fund the purchase of a garage prefabrication mill. The third loan was made in 1990, in the amount of $66,223.96, again to Bullock and his mother to purchase real estate. All three loans were repaid in full with interest.[7]

Unfortunately for Bullock, in 2001, after learning of the existence of the trust, Bullock's brothers, two of the beneficiaries of the trust, filed an action in Illinois state court for breach of his fiduciary duty by engaging in self-dealing. The state court found that Bullock did not have any malicious motive, but held that Bullock was liable without regard to motive.[8] A judgment was entered against Bullock in the amount of $250,000.00 and the court created constructive trusts of Bullock's assets to secure the judgment. BankChampaign was appointed trustee of those constructive trusts and replaced Bullock as trustee of his father's trust.[9]

Subsequently, Bullock requested to liquidate the assets of the constructive trusts to satisfy the judgment. BankChampaign, as trustee, blocked liquidation of the assets.[10] In 2009, Bullock filed a Chapter 7 bankruptcy case in an attempt to discharge the Illinois judgment. BankChampaign then filed an adversary proceeding requesting that the bankruptcy court declare the judgment nondischargeable under 11 U.S.C.A. § 523(a)(4), as a debt arising from defalcation while acting as a fiduciary.

The bankruptcy court granted BankChampaign's motion for summary judgment and found the debt nondischargeable. The bankruptcy court reasoned

