

Not-For-Profit Hospitals Face New Challenges Accessing Capital

By James Unland and Kevin Ponton¹

March 3, 2003

There is growing concern among a selected group of investment bankers, financial advisors, rating agencies and bond insurers that the not-for-profit hospital sector could be entering a severe capital crunch during a period in which capital needs in this important sector will be significant, if not unprecedented. Some aspects of this situation combined with some recent events raise concerns about the ability of large segments of this sector to, in fact, remain viable longer term or to remain viable in a not-for-profit configuration.

2002-2003 Brings A Departure From The Traditional Hospital Borrowing Cycle

Because not-for-profit hospitals do not acquire or possess equity capital in the form of stock, they generate capital mainly by either producing positive net cash flow earnings, raising tax-deductible contributions or through borrowing using various debt instruments. Nearly every 501(c)(3) hospital experiences a virtually unremitting need for debt capital in order to replenish and upgrade facilities and equipment and, in some instances, redirect major services such as transitioning from inpatient to more outpatient oriented delivery. Historically, however, because of the longer planning cycles involved in major projects and the complexity of borrowing large amounts at one time, most hospitals have tended to embark on major capital projects every several years, often every seven to 10 years. These projects can sometimes be dovetailed, at least to some extent, with periodic interest rate cycles that provide windows of lower interest rates.

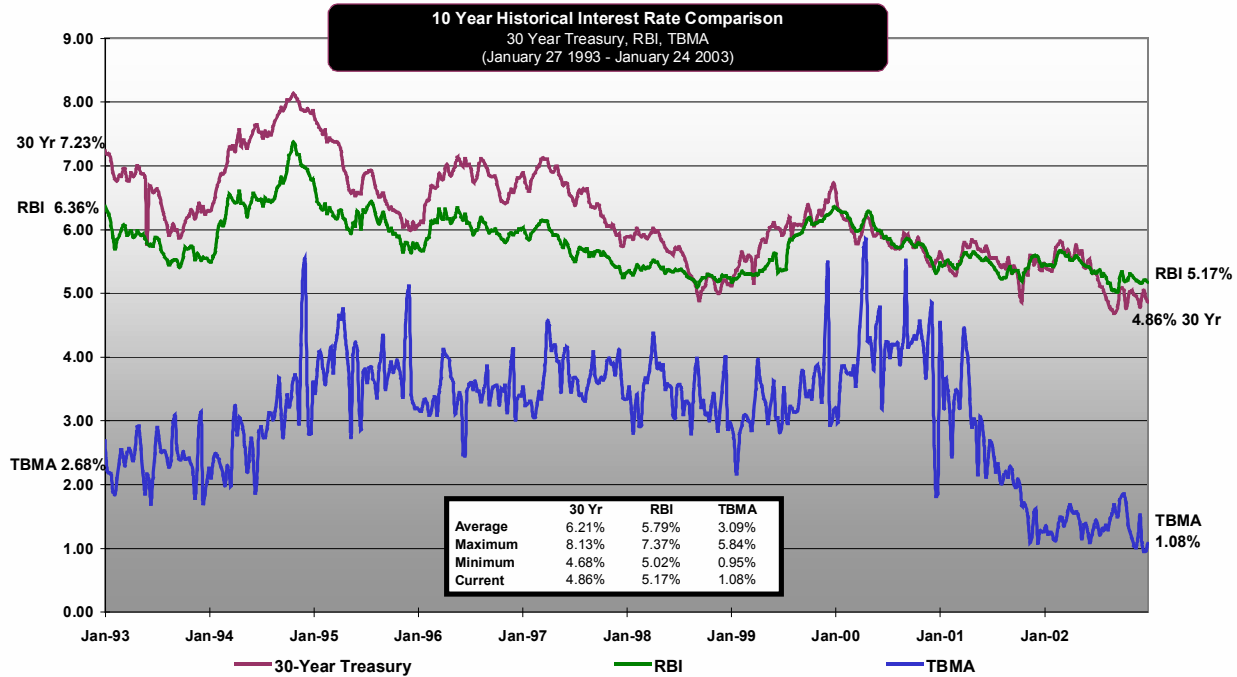
The exhibits on the following page illustrate that some hospitals have the ability to undertake major borrowings when interest rates are falling or have fallen. If one examines the two exhibits—the top exhibit showing some key interest rate fluctuations during the 90s and the bottom exhibit showing the amounts of tax-exempt bonds issued by hospitals—one can see that during some significant declines in interest rates borrowing shot up, as occurred in 1993 and 1998. Some of this borrowing, of course, represented the refinancing of prior hospital debt, but much of it was also for new projects.

This phenomenon of incurring debt when interest rates are relatively low, known as ‘borrowing elasticity,’ should surprise no one. Whether the ability of a portion of hospitals to take advantage of the timing of interest rate fluctuations is the result of their own design, a result of just good luck or a combination of factors—has not, in itself, been explicitly studied. We theorize that even though hospital capital projects cannot simply be ramped up on a moment’s notice, hospitals do have a bit of flexibility as to the timing of their capital accumulation, probably within a window of between 12 and 18 months all other things being equal, and assuming that the truly time-consuming planning and certificate-of-need issues have been resolved prior to entering the ‘borrowing window.’

Even though the exhibits address the spikes in *tax-exempt* borrowing, hospitals and their subsidiaries do often engage in taxable or conventional borrowing as well, including such things as leases, bank loans, and private taxable placements, and even though tax-exempt debt is, logically, the favored instrument, it follows that hospital CFOs will behave so as to take advantage of lower interest rates to the extent practicable whether or not the debt is tax-exempt or conventional.

Yet that is not happening now to the extent it should. The historic patterns of behavior are not holding true to the extent justified by the low interest rates of the recent two or three years. We are not seeing the kind of borrowing elasticity that one would expect given the traditional capital accumulation cycles, and the reasons for this point to significant longer term concerns relating to the ability of the not-for-profit hospital sector to obtain major capital financing in the coming years.

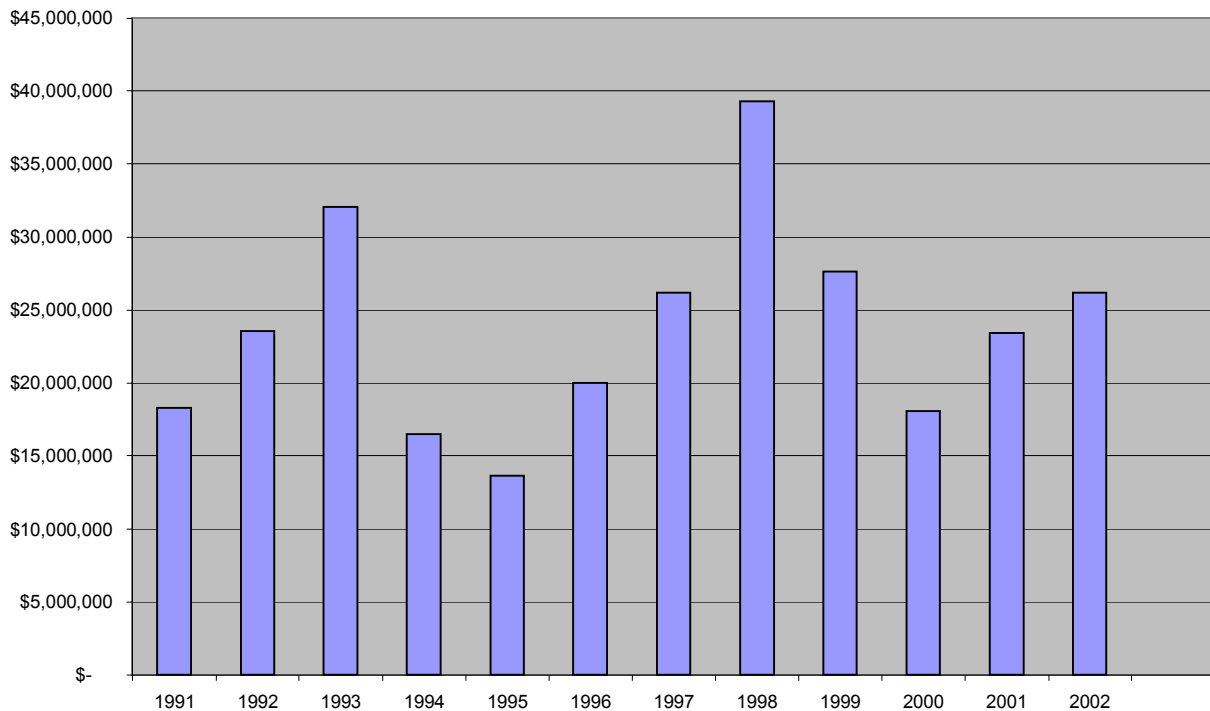
¹ James Unland is President of The Health Capital Group and Editor of the Journal of Health Care Finance. Kevin Ponton is a Vice President of Ziegler Capital Markets in Ziegler’s New York office.



Source: Ziegler Capital Markets Group. Data provided by Bloomberg.

Total Healthcare Bonds Principal Issued (000s)

(source: The Bond Buyer Thomson Financial Yearbook)



Late 90s Events Jolt the Hospital Capital Markets

Two high-profile large bankruptcies and credit defaults in the late 1990s—that of the Allegheny Health, Education and Research Foundation (AHERF) and that of the Harvard Pilgrim Health Care managed care plan—jolted rating agencies, bond insurers, investment bankers, and bond buyers. This was especially true with regard to the AHERF bankruptcy filing in July of 1998 and AHERF’s concomitant defaults on \$353 million of MBIA-insured tax-exempt debt and \$161 million of uninsured tax-exempt debt. An article to be published in the summer 2003 issue of the *Journal of Health Care Finance*² presents an in-depth look back, comparing certain pre-AHERF bond market and credit characteristics with post-AHERF characteristics, concluding that:

“...An analysis of hospital tax-exempt bonds issued before and after the AHERF bankruptcy, demonstrated that despite the decline in market rates for tax-exempt securities in the post-AHERF period, bonds issued by hospitals and systems carried higher coupon rates than they did in the pre-AHERF period. There was a significant decline in the proportion of hospital/system bonds that were insured from the pre- to the post-AHERF period. Bond insurance firms tightened their credit criteria after the bankruptcy, which may explain, in part, why the proportion of insured bonds declined. We conclude that hospital bonds are now viewed as riskier instruments than they were prior to the AHERF bankruptcy. This is reflected in higher coupon rates for both insured and uninsured bonds and fewer insured bond issues....”³

Both the rating agency Standard & Poor’s (“S & P”) and the bond insurer AMBAC recently confirmed the significant impact of the AHERF default in interviews conducted by James Unland with, respectively, Martin Arrick, the head of S & P’s public finance health care ratings group,⁴ and Steve Renn, the head of AMBAC’s health care insurance group.⁵ These important credit gatekeepers have, by their own admission, become more cautious and more conservative in analyzing not-for-profit hospital credits.

² “Changes in the Hospital Tax-Exempt Bond Market: The Aftermath of the AHERF Bankruptcy” by Caryl Carpenter, Michael McCue and Sun Moon to be published by the *Journal of Health Care Finance*. To receive a pre-publication copy available by mid-March 2003, email HealthFinanceJournal@yahoo.com and reference the article title with the request.

³ Excerpt from conclusions section of above article (see Footnote 2).

⁴ Excerpt from the interview with Martin Arrick of S & P:

James Unland: Has S & P become a bit more conservative about hospital credits compared with a few years ago?

Martin Arrick: There are whole lines of questioning that did not exist that in the mid-90’s and late 90’s that have started consuming a lot more of our time with a hospital’s management... A lot of that started post-AHERF and Harvard Pilgrim—and Harvard Pilgrim was an issue in my mind equal in importance to AHERF as a sentinel event...But, pre that time, people would come in with a project or a forecast that tended to be believed. Our people have gotten a lot more, I don’t want to say cynical, that wouldn’t be the right word. But people are a lot more of the attitude that “I am from Missouri, you really have to prove it to me.” I think in this whole period, ’98, ’99, 2000, there is not an analyst out there who wasn’t humbled by some prior credit decision they had made. They rated something A and a year and a half later it is triple B or worse. Everybody learned the hard way that there is a need to be a lot more skeptical about a lot of this, especially the hospital’s forecast. I think this aspect is probably inherently more conservative than it was in the early ‘90’s.

⁵ Excerpt from the interview with Steve Renn of AMBAC:

James Unland: From your point of view, was there a point in time a few years ago when the default of the Allegheny Health, Education and Research Foundation (AHERF), and maybe one or two others, caused a rethinking on the part of your bond insurance company and, perhaps other companies as well? It seems as if the AHERF default was a major wake-up call or jolt to a lot of people.

Steve Renn: I think, certainly, that it was a wake-up call...We talked about AHERF for a long time. It was a nasty car wreck that turned a lot of heads. It stimulated conversations internally regarding the magnitude of the severity of loss. AHERF also stood for a pretty low recovery value for a completely melted down healthcare system. ... The value of a closed hospital and the assets associated with a closed hospital have much less value than assets in a going concern mode—generating patient accounts receivable and treating patients. AHERF stood for that... The AHERF default, I think, reinforced our belief in being prudent in terms of the amount of exposure to any one institution and being very diversified.

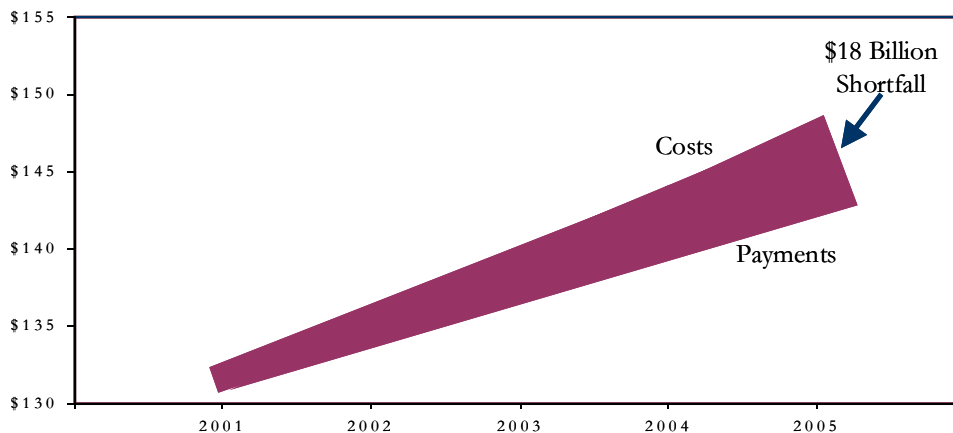
NOTE: the above quotations of Martin Arrick and Steve Renn are excerpted from interviews conducted during the summer of 2002 following the release of the in-depth Health Finance Forum report, “The Future of Not-For-Profit Healthcare Capital Financing.” Email HealthFinanceJournal@yahoo.com for a copy of or more information about this report.

Other Factors Have Affected Perceived Hospital Credit Risk and Credit Availability

Other factors in addition to the spectacular bond defaults of the late 1990s have affected the perception by credit grantors of not-for-profit hospitals' credit risks, including among other things: (a) the continuing residual effect of the 1997 Balanced Budget Act on hospital reimbursement and other persistent reimbursement concerns, (b) thin hospital operating margins, with hospital positive net cash flow too often coming from investment income, (c) lower investment income as the result of lower yields from investments, (d) losses on ownership of non-core businesses such as medical practices, and (e) growing vulnerabilities with respect to loss of hospital market share to physician-owned specialty diagnostic/treatment centers.

The reimbursement factor alone has been stressful for hospitals and is expected to worsen during the exact period of time of significant capital need:

Projected Total Medicare Payments and Costs for Hospital and Hospital-Based Services⁶



Reprinted with permission – The Lewin Group and the American Hospital Association.

The upshot of greater conservatism on the parts of credit gatekeepers such as rating agencies and bond insurers is that the number of bond issues that are insured has declined proportionately at the same time that relative rating-adjusted prices and yields for not-for-hospitals have increased in response to the higher sector risk perception.⁷ Blended hospital 'underlying'⁸ credit ratings have also declined irrespective of bond insurance, with downgrades tending to outpace upgrades since the volatile 1998-2000 period.⁹ The net effect is disturbing in that tax-exempt credit ratings that are considered to be investment grade are more difficult to obtain, and those organizations who have had such ratings must fight to maintain them.

Not only has the risk assessment side of the equation changed for not-for-profit hospitals but the supply of tax-exempt bond buyers has decreased. The Health Finance Forum's extensive report¹⁰ of June 2002 indicated that the universe of purchasers of tax-exempt debt has declined significantly in the past 20 years, to

⁶ "The Future of Not-For-Profit Healthcare Capital Financing," by the Healthcare Finance Forum, June 2002, p. 14.

⁷ "Changes in the Hospital Tax-Exempt Bond Market: The Aftermath of the AHERF Bankruptcy" by Caryl Carpenter, Michael McCue and Sun Moon to be published in June 2003 by the Journal of Health Care Finance. The article concludes: "...Several findings provide support for the argument that bond insurers tightened their credit policies after the AHERF bankruptcy. First, insured bonds carried lower yields than uninsured bonds in both periods, but there was a large increase in the yield spread from the PRE to POST period. Second, the proportion of hospital bonds that were insured was lower after the bankruptcy. Prior to AHERF, 61 percent of newly issued bonds were insured; however, after AHERF, the number of newly issued insured bonds declined to 47 percent. Third, those that were insured in the POST period had better credit quality characteristics than in the PRE period. The hospitals and systems that issued insured debt in the POST period faced less competition, had lower HMO penetration in their markets, higher occupancy rates, lower debt to equity ratios and were less dependent on government payers – all signs of less credit risk...."

⁸ The term 'underlying' when applied to credit ratings means the intrinsic, specific rating of the hospital credit itself.

⁹ See the Health Finance Forum report of June 2002, "The Future of Not-For-Profit Healthcare Capital Financing."

¹⁰ The Healthcare Finance Forum was founded in the early 1990s among a multidisciplinary group of firms involved in healthcare finance activities and consists of the following firm members: Adventist Health Systems, AMBAC Indemnity Corporation, Deloitte & Touche Consulting, Gardner Carton & Douglas, the Healthcare Financial Management Association, Marshall Erdman & Associates, McManis Consulting, PeaceHealth, Spencer Stuart, Standard & Poor's Corporation, The Wharton School of Business, University of St. Thomas (Minneapolis) and Wellspring Valuation Ltd.

the point where about 50 institutions now buy nearly 80% of all tax-exempt paper. This is contrasted with a situation in the early 1980s in which there were literally hundreds of institutions with an appetite for tax-exempt healthcare yields, combined with thousands of outlets for what was then a thriving retail market selling directly to small investors.¹¹

Cost of Capital Is One Issue, But Access to Capital Is the Real Concern

The heightened perception of hospital credit risk on the part of both credit grantors (rating agencies, bond insurers, bank issuers of letters of credit) and purchasers of tax-exempt debt, combined with the persistence of negative factors affecting the sector (tight reimbursement, etc.), is occurring at a time when the industry is expected to require up to a half trillion dollars in capital over the next 10 years.

No one needs to be told how capital-intensive the hospital industry has become, whether related to inpatient facilities, outpatient facilities, advanced diagnostic equipment or up-to-date operating and procedure rooms. No one needs to be told of the implications in terms of the need for modern facilities and equipment to treat an aging population both in the inpatient and outpatient modalities. Yet, the average age of the physical plants of hospitals in the not-for-profit sector has continued to rise, increasing 18% since 1990.¹² Major capital development projects cannot be put off forever, nor can the acquisition of modernized diagnostic and treatment equipment.

The concern is that literally several thousand not-for-profit hospitals are going to face unprecedented capital needs during a time of more restricted access to capital when, in fact, new capital acquisition modalities need to be emerging.

Historically, there has been a commonly held belief in the banking and investment banking industry that a hospital is bankable at a price, meaning that from the bond purchaser's perspective the principle of borrowing elasticity works in reverse; in other words, if the tax-exempt yield is high enough, bonds will sell. In this present credit environment, however, this traditional view of borrowing elasticity does not seem to apply. First, as mentioned above, the credit grantors or gatekeepers who determine whether bonds can be rated as investment grade are more conservative, and sector developments are by no means abating their concerns.¹³ Second, the market for unrated tax-exempt bonds and notes is much more limited than in years past, with a diminished retail sector and with bond funds shying away from higher risk tax-exempt credits.

In our opinion, the primary factor to watch in the next year or two is not whether hospitals are paying higher prices for debt—which we know they already are—but *the extent to which they can borrow* significant funds at all. At first blush this may appear to be somewhat melodramatic speculation, but a close examination of the facts and recent literature reveal sobering trends to the veteran investment banker.

Long Term Implications

Absent some improvement in the capital access picture, what are the longer term alternatives for the not-for-profit sector? One school of thought is that with the shrinking number of tax-exempt bond buyers and in light of the restrictions on 501(c)(3) hospitals relating to providing equity participations, the sector will face strong pressure to undergo a major new wave of consolidation or start converting not-for-profit hospitals to for-profit (including selling out to for-profit hospital chains). If this latter scenario emerges on a significant scale, then the capital crunch of the next 10 years could precipitate large-scale, fundamental changes in the complexion of the hospital industry itself.

¹¹ There is, technically, still a retail market, meaning that a person can actually purchase tax-exempt bonds for his or her individual account; however, from a practical standpoint, most individuals who do acquire tax-exempt investments do so through bond funds in order to diversify their own risk. Thus, the tax-exempt bond funds have amassed enormous buying power.

¹² "The Future of Not-For-Profit Healthcare Capital Financing," by the Healthcare Finance Forum, June 2002, p. 19.

¹³ S & P's January 2003 report describes more expected stresses on the not-for-profit hospital sector. For a copy contact S & P or email HealthFinanceJournal@yahoo.com.

As the vulnerability of not-for-profit hospitals in terms of capital acquisition becomes more widely known, it is likely that some large-scale studies and surveys of this sector will reveal more about the capital needs of these hospitals and their ability to access capital when it is needed—studies that may shed more light on the true extent of this capital access challenge.