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The Financial Crisis Facing America's Hospital Industry: Part II

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Editor's Note: *Part I appeared in the December/January 2009 issue and provided an overview of the impact of the credit crisis on financing hospitals, as well as the micro- and macroeconomic drivers of financial distress for hospitals. Part II discusses the state of the capital markets for hospitals nationwide.*


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Capital for maintenance, technology and growth is a requirement to maintain market share in the competitive hospital industry. The hospital industry is particularly dependent on capital access because its ability to provide quality service (and produce operating revenue) is heavily dependent on monetizing tangible assets such as land, facilities, medical equipment and information technology. Hospitals finance themselves through a variety of capital sources including operating cash flow, existing liquid investments and cash, bond debt (both tax-exempt and taxable), commercial banks, specialty finance companies (such as equipment leases, lines of credit, real estate), philanthropy, investor equity and various government subsidies.

Hospital lending and borrowing entails many unique issues. Hospitals typically have slow collection cycles, an average of 75 to 120 days, compared to 30 to 60 days for most industries. For asset-based lenders, this factor is important because it effectively lengthens the duration of an exit during a forced liquidation scenario. For bonds and other types of financing, increased liquidity (versus most industries) and a strong balance sheet tend to be requirements from bond investors. For all hospital lenders, the enforceability of liens is an important issue.

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Intensive Care


Shane A. Passarelli

Given the importance of government payors, a lender's inability to obtain a fully-perfected lien on government accounts receivable typically reduces the amount that can be borrowed. The widely accepted right of Medicare and Medicaid to recoup past overpayments or other liabilities from ongoing payments, even if the hospital is in bankruptcy, also creates significant issues for lenders. Examples of situations in which future payments may be offset include Medicare Cost Report liabilities, lien- or appeal-based payments such as personal injury or worker's compensation claims, or risk pools that have unpredictable costs such as capitated payments from health plans.

The increasing emphasis on finding and punishing health care fraud by the federal government, which can result in the imposition of treble damages and dismissal from the Medicare Program, also adds uncertainty to the hospital's ability to borrow in the capital markets and increases costs for those that do. Bankruptcy workout costs tend to be significantly higher in health care cases due to the potential numerous stakeholders and constituents involved, with examples including Medicare, Medicaid, health plans, regulatory agencies, accreditation entities, shareholders, community members, secured creditors, financial guarantors, vendors, patient care ombudsmen and unsecured creditors.


George D. Pillari

In the end, lenders often cannot lend as aggressively to hospitals compared to most industries due to quality-of-earnings issues and higher bankruptcy workout costs, otherwise they face the risk that they may not recover their original investment. As Ben S. Bernanke, the Federal Reserve Chairman, told the U.S. House of Representatives a year ago:

> [A]s the rising rate of delinquencies of subprime mortgages threatened to impose losses on holders of even highly rated securities, investors were led to question the reliability of the credit ratings for a range of financial products, including

structured credit products and various special-purpose vehicles. As investors lost confidence in their ability to value complex financial products, they became increasingly unwilling to hold such instruments. As a result, flows of credit through these vehicles have contracted significantly.[1]

To say that credit in America has "contracted significantly" is an understatement. Many believe that America may be on the verge of suffering through its worst financial crisis since the Great Depression. During the current credit crisis, capital—even from the most reliable of sources—has evaporated. An unprecedented era of credit stability has been replaced by a frightening deterioration of credit quality among commercial banks and debt investors. Through December 2008, 25 banks and thrifts have failed (including Washington Mutual, the largest bank failure in history[2]) compared with three in 2007 and zero for 2006 and 2005.[3] Major money center banks such as Citibank have survived by diluting shareholders with massive capital raises and government-funded bailouts.[4] Bear Stearns needed a bailout sale to avoid bankruptcy,[5] and Lehman Brothers, one of the most prestigious institutions on Wall Street, declared bankruptcy.[6] The government seized control of mortgage finance companies Fannie Mae and Freddie Mac, which own or guarantee approximately half of the nation's $12 trillion in outstanding home mortgage debt because of mounting home loan losses.[7] This credit crisis has and will continue to wreak havoc on the capital markets and the availability and cost of capital to hospitals.[8]

Access to capital was robust relative to historical metrics before the credit crisis. For health care in general and hospitals in particular, there were many options available, including the taxable and tax-exempt bond market, commercial banks, bond insurers, specialty health care lenders, philanthropy and investor equity via real estate investment trusts (REITs), private-equity firms and physician-equity syndications. Further, before the credit crisis, the supply of capital exceeded demand for credit. Competition for quality assets was fierce among all asset classes. Due to low levels of credit losses relative to historic metrics, debt sources increasingly pushed the envelope, providing capital to weaker and less-creditworthy borrowers. While the hospital industry was traditionally identified by investors as undervalued due to its complexities and inefficiencies, more dollars began to flow into the sector due to a lack of acceptable investment opportunities in other industries.

Health care facilities traditionally operated at low or near-zero default rates and were regarded by investors as a noncyclical safe haven. As attractive risks, they were easily insured by financial guarantors such as MBIA or Ambac. Since most health care facilities were viewed as essential community assets and as one of the largest employers in town, lenders and debt guarantors slept well with these risks in their portfolios.

But times have changed. Perhaps this really is the beginning of the end for many hospitals that loaded up on debt when money was cheap and easily available. In recent years, there has been an increasing level of health care defaults and, as previously mentioned, facilities continue to be shuttered on a regular basis. "Standard & Poor's has taken a meat-ax to the credit ratings of not-for-profit hospitals of late. During the first six months of 2008, credit downgrades for nonprofit hospitals and health systems rated by S&P almost doubled, while upgrades fell, compared with the same period during the previous year. The agency downgraded 31 not-for-profits during that six-month period and upgraded only 11."[9] This trend continued into the fourth quarter of 2008 as credit availability continued to tighten. Moody's downgraded 18 hospital bond ratings in October and November 2008 while upgrading only one.[10]

Further complicating matters is the lack of financial covenants (commonly referred to as "covenant-lite") in many transactions completed in the past several years. While many lenders were chasing deals and competing with each other, credit standards became relaxed and many lenders were willing to waive the inclusion of financial and other kinds of covenants. Without the early warning system of covenant breaches, however, lenders and other players that rely on the hospital to provide financial information end up facing the immediate risk of insolvency or a defensive bankruptcy filing without prior notice. Lenders are now realizing that they do not have as much protection in their existing lending agreements as they would like and are frequently trying to establish more restrictive covenants, in exchange for allowing "workouts" of existing troubled loans or bonds.

Few hospitals that historically obtained financing through the taxable and tax-exempt bond markets used fixed-rate debt.[11] Similar to an adjustable-rate vs. a fixed-rate home mortgage, many hospitals took on interest-rate exposure with variable-rate securities. Similar to adjustable-rate home mortgages, in the short-term, there were potential interest-rate cost savings using variable-rate securities. However, as the taxable and tax-exempt bond market became less reliable, borrowing costs soared. Few hospitals had hedges in place against interest-rate risk.[12] As a result, many hospitals saw their borrowing costs jump significantly. As is the case with a homeowner, if one were to take a risk of a potential increase in interest rates, one should have adequate cash flow and/or liquidity reserves to absorb potentially higher borrowing costs. Unfortunately for many hospitals that used variable-rate debt, they did not reserve adequate liquidity to absorb increased borrowing costs.[13]

Compounding the problem for hospitals is an exotic class of securities known as Auction Rate Notes (ARNs). Many hospitals borrowed through the use of such notes without fully understanding the risks involved in these transactions. The market for ARNs effectively disappeared in the weeks following the subprime mortgage meltdown. ARNs work much like the commercial paper market in that borrowers enter the market

1 Chairman Ben S. Bernake, "The Economic Outlook," before the Committee on the Budget, U.S. House of Representatives, available at www.federalreserve.gov/newsevents/testimony/bernanke20080117a.htm (Jan. 17, 2008).

2 Eric Dash et al, "Government Seizes WaMu and Sells Some Assets," The New York Times on Sept. 25, 2008, available at www.nytimes.com/2008/09/26/business/26wamu.html?scp=1&sq=government%20seizes%20wamu&st=cse.

3 FDIC, "Failed Bank List," www.fdic.gov/bank/individual/failed/banklist.html (last visited Dec. 29, 2008).

4 "Citigroup Raises $6 Billion in Capital Markets," available at dealbook.blogs.nytimes.com/2008/04/22/citigroup-raises-6-billion-in-capital-markets; Joint Statement by Treasury, Federal Reserve and the FDIC on Citigroup,(Nov. 23, 2008), available at www.federalreserve.gov/newsevents/press/bcreg/20081123.htm.

5 BusinessWeek, "Bear Stearns' Big Bailout," available at www.businessweek.com/bwdaily/dnflash/content/mar2008/db20080314_993131.htm (March 14, 2008).

6 CNNMoney.com, "The Meltdown," available at money.cnn.com/2008/09/15/news/companies/lehman_brothers/index.htm (Sept. 21, 2008).

7 CNBC.com, "Government Takes Control of Fannie, Freddie," available at www.cnbc.com/id/26590793 (Sept. 8, 2008).

8 See, e.g., Reed Abelson, "Disappearing Credit Forces Hospitals to Delay Improvements," The New York Times at B1 (Oct. 15, 2008).

9 www.fiercehealthfinance.com/story/s-p-downgrades-non-profit-hospitals-rise-sharply/2008-08-27 (Aug. 27, 2008).

10 www.fiercehealthfinance.com/story/moodys-downgrades-18-hospital-bond-ratings-two-months/2008-12-17 (Dec. 17, 2008).

11 See, e.g., Harvey Lipman "Financial Crisis Affects Local Hospitals" (Oct. 10, 2008), northjersey.com/health/financial_crisis_affects_local_hospitals.html; Elizabeth O'Brien, "Hospitals Going Variable," from The Bond Buyer, available at www.accessmylibrary.com/coms2/summary_0286-12364541_ITM.

12 See, e.g., Ross Kerber, "Subprime Crisis Filters to Mass. Nonprofits," The Boston Globe, Feb. 15, 2008, available at www.boston.com/business/articles/2008/02/15/subprime_crisis_filters_to_mass_nonprofits.

13 See, e.g., Tiffany Beck, "Bondwoes Take Toll on Local Hospitals," Orlando Business Journal, March 14, 2008, available at orlando.bizjournals.com/orlando/stories/2008/03/17/story2html.

for short-term variable-rate debt and must continue to borrow new funds every few weeks to pay off the old funds. In stable markets, variable-rate securities are an inexpensive form of financing, but this was not the case in volatile markets where investors were running scared. In the absence of willing purchasers, hospital and health systems quickly saw their borrowing costs jump from approximately 5 percent to 15 percent, choking off the supply of capital. Suddenly, the taxable and tax-exempt bond markets were no longer stable and consistent sources of capital for investment-grade hospitals.

The news is much more severe for sub-investment-grade and distressed hospitals. There is a limited appetite for noninvestment-grade credits from retail and institutional bond buyers. Today, there is a relatively small universe of active institutional buyers. In the authors' estimation, there are perhaps 50-75 total accounts nationally with only 30-35 active, and even fewer that are willing to buy bonds at the range of BBB or below. The active "market place" for hospital bonds has severely reduced its size.

In addition to a smaller group of potential purchasers, the credit crisis has made the bond purchasers more careful. Bond purchasers are (1) imposing tighter covenants, (2) asking for more security (debt-service reserve-funding, lockboxes, etc.), (3) expanded reporting and disclosure requirements, and (4) increased transparency through more frequent and direct institutional-investor interactions. All of these hurdles make issuing bonds all the more difficult.

Bond insurers, suffering massive losses from the subprime mortgage exposure, are pulling back from or moving out of the market. MBIA and Ambac, two of the largest insurers of municipal debt, have themselves been downgraded and no longer issue the AAA rating on their guarantees.[14] In addition to creating liquidity problems for hospitals, the absence of bond insurance makes the purchasers of bonds more cautious as well because they cannot purchase additional credit protection for their investment decisions. Finally, the municipal market for bonds has been severely debilitated by the credit deterioration of most monoline bond insurers, primarily due to guarantees provided by the monolines on subprime-related mortgage securities. As rating actions continue with monolines,[15] the municipal bond market will continue to remain volatile.

Debt-rating agencies are paying close attention to the fundamentals of underlying credits compared to a year ago. As hospitals attempt to sell bonds in support of their operations, credit-rating agencies such as Moody's, Standard & Poor's and Fitch assign credit ratings for issuers of certain types of debt instruments, as well as for the debt instruments themselves. These rating agencies are supposed to conduct a thorough review of the many business aspects of each hospital or hospital system that is issuing debt and grade its credit-worthiness. This grade has a direct and real impact on the hospital's cost of borrowing. A higher rating, which indicates better credit quality, translates into a lower cost of funds for the borrower. The collapse of the bond insurers, and the loss of confidence in hospitals as noncyclical safe havens, have crippled the industry's ability to raise money at the record pace in the last decade.

Alternative sources of direct capital for noninvestment grade and distressed hospitals have become limited, more expensive and more restrictive than in the past. While there were many specialty health care finance companies and REITs competing for business before the credit crisis, now only a handful are left standing with an active interest in the health care industry. These specialty finance companies and REITs were providing lines of credit, operating and capital leases, sale leasebacks and mortgages to fund vital working capital, capital expenditures and plant expansion and improvements for many of the noninvestment grade and distressed hospitals before the credit crisis. Credit standards have tightened and interest rate spreads have widened 100-500 basis points during this financial crisis. Fewer entities are willing to lend in risky situations. For example, many lenders historically perceived debtor-in-possession (DIP) financing to be a lucrative line of business because of its low risk and high return value proportion. DIP loans tended to be structured as last-in and first-out vehicles because they have a super-priority, fully-perfected lien from the bankruptcy court and tend to be over-collateralized by all the assets of the borrower. In addition, despite a lower risk profile, lenders are typically able to charge borrowers higher interest rates and fees on short-term loans. According to the *Wall Street Journal*, credit has now become so scarce that many companies filing bankruptcy are unable to obtain DIP financing.[16]

> It may well be that credit is running out for hospitals. The credit crisis has resulted in intense pressure on hospitals nationwide. Access to capital is critical in financing hospitals because they are capital-intensive businesses with thin profit margins and slow collection cycles. There will be few safe havens in the sector... In a system in which the flow of funds is controlled by a handful of insurance companies and the federal government, it is difficult to see how many of today's hospitals will make it out to the other side of the current credit crisis.

With regard to bank letters and lines of credit (LOC), most commercial banks, especially foreign banks, have retreated from this market. Bank letters are much more difficult than LOCs due to credit default exposure. LOCs are no longer considered a profitable business line by many banks. Borrowers should expect (1) a much-higher degree of selectivity, (2) shorter LOC renewal terms (one, three or five years), (3) more restrictive and highly-negotiated covenants and security provisions (similar to bond insurer requirements, but sometimes more or different requirements), and (4) explicit

[14] TheStreet.com, "S&P Downgrades MBIA, Ambac," available at www.thestreet.com/story/10420062/1/sp-downgrades-mbia-ambac.html (June 5, 2008); Reuters.com, "Moody's cuts MBIA Insurance to 'Baa1'," available at www.reuters.com/article/rbssFinancialservicesandRealEstateNews/idUSN0737320320081107 (Nov. 7, 2008); The Bond Buyer.com, "Moody's Drops Ambac Insurer Rating," available at www.bondbuyer.com/article.html (Nov. 6, 2008).

[15] A monoline guarantees the timely payment of bond principal and interest when an issuer defaults. For further reference, see en.wikipedia.org/wiki/Monoline_insurance (last visited on Oct. 31, 2008).

[16] Wall Street Journal, "DIP Loans Are Scarce, Complicating Bankruptcies" (Oct. 17, 2008).

tie-ins with other banking services, such as investment management. Hospital borrowers are seeing much less use of LOC-backed variable-rate demand note structures.

Many of the failed or failing hospitals are municipally owned in places like Texas and California, or are health care districts (quasi-governmental entities). These entities have been hurt disproportionately by the credit crisis due to their reliance on government funding. "Hospitals supported by state and local governments have become a significant drain on state and county tax dollars. In some cases, budget shortfalls at small, county-supported community hospitals could threaten the financial viability of the entire county," according to the A&M study. As tax revenues decrease, one would expect to see an increase in the financial failures of these hospitals.

Conclusion

A former chairman of the Federal Reserve said about the Great Depression: "As in a poker game where the chips were concentrated in fewer and fewer hands, the other fellows could stay in the game only by borrowing. When their credit ran out, the game stopped."[17] It may well be that credit is running out for hospitals. The credit crisis has resulted in intense pressure on hospitals nationwide. Access to capital is critical in financing hospitals because they are capital-intensive businesses with thin profit margins and slow collection cycles. There will be few safe havens in the sector. Today, many highly-rated hospitals with significant cash on hand still hit the panic button and freeze capital spending or institute a hold on new hires when there is a 400-point drop in the Dow Jones Index.

Is this unnecessary anxiety or a real fear of losing the access to capital necessary to execute on a mission? Perhaps it is a bit of both. In a system in which the flow of funds is controlled by a handful of insurance companies and the federal government, it is difficult to see how many of today's hospitals will make it out to the other side of the current credit crisis. ■

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[17] Marriner S. Eccles, Beckoning Frontiers: Public and Personal Recollections, at 499 (New York: ed. Alfred A. Knopf, 1951).