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Health Care Financing Trends: What Do They Foreshadow?

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This article explores some current health care financing trends and speculates on what they may portend for work in a health care restructuring professional's "pipeline."[1] While there are many kinds of health care enterprises on which to focus, we have chosen two to single out as representing the likeliest restructuring possibilities in the foreseeable future: (1) hospital facilities, systems and networks; and (2) residential facilities that are designed to attract more mature, senior-living populations, generally known as Continuing Care Retirement Communities (CCRCs). Before we analyze current trends in the financing of these businesses, the current state of these two types of health care endeavors needs to be explored to provide an overview of their current travails, concerns that point to restructuring possibilities several years down the road.

Current State of the Hospital Industry

Let's start with a brief but rather wide-ranging review of the hospital industry. Five readily discernable trends have bedeviled hospital operations over the past half-decade or so, and all indications are that these conditions will continue for at least that length of time into the future. These five trends include: (1) a steady decline in patient volume; (2) pressure on operating income from bad-debt write-offs, increased charity cases and Medicaid and Medicare underpayments; (3) decreased nonoperating margins from investments and contributions, which have greatly deteriorated since the 2008 fiscal crisis; (4) limited access to capital and financing for both "have" and "have-not" hospitals; and (5) what one of us calls "get big or get out."

Declining Patient Volumes

Since roughly the middle of the last decade, there has been a substantial and continuing decline in inpatient volumes.[2] Perhaps more alarming from an industry perspective is that many hospitals that are reporting inpatient declines are also reporting an incipient decline in outpatient volume.[3] Patient volume decline is generally more pronounced at "mid-sized" hospitals, or facilities with between 250-500 beds.[4]

Eroding Operating Income

Many hospitals, particularly those in urban and suburban settings, also are experiencing steep increases in uncompensated care. Three factors contribute to this: bad debt, charity care, and Medicare and Medicaid underpayments. Government underpayments to U.S. hospitals were in excess of $56 billion in calendar year 2012, with, on average, Medicare only reimbursing 86 cents and Medicaid only reimbursing 89 cents for every dollar that hospitals spent caring for patients covered under these government programs.[5] Since 2000, the U.S. hospital industry estimates that facilities of all types and sizes have provided more than $413 billion in uncompensated care to patients.[6]

Eroding Nonoperating Income

In the past, nonoperating income from investments, endowments, etc., offset — or at least mitigated sufficiently — shortfalls in a hospital's operating revenue. However, nonoperating income has fallen precipitously since 2008 at most hospitals, due to both a paucity of new giving and a reduction in the value of the portfolios held.[7] When you combine decreased patient volume with substantially reduced operating and nonoperating revenues, you begin to understand the cash squeeze that hospitals now face.

Constricted Access to Capital

Given these stresses on revenue, both "have" and "have-not" hospitals have begun to struggle with ready access to capital, a trend exacerbated over the past decade or so.[8] In our recent experience, virtually all nonprofit hospitals, whether newly constructed or materially updated, have been financed with federally tax-exempt bonds issued

1 Both authors have substantial experience in health care restructuring, and one chairs a state authority that annually provides several billion dollars in taxable and tax-exempt funding for health care endeavors and developments. "Strategic Plan: Fiscal Years 2013-2015," Illinois Finance Authority at 3, *available at* www.il-fa.com/sites/all/themes/ifa/docs/strategic-plan-v12.pdf. The authors believe that they can offer some educated assumptions, as well as possibly some calculated forecasts, as to what the industry will look like over the next few years.

2 "The Financial Health of U.S. Hospitals and Healthcare Systems," Healthcare Financial Management Association at 2, 5 (January 2009), *available at* www.novationco.com/media/industryinfo/hfma_financial_health_090323.pdf.

3 *Id.* at 3, 5.

4 *Id.* at 5.

5 "Underpayment by Medicare and Medicaid Fact Sheet," American Hospital Association (2014), *available at* www.aha.org/content/14/2012-medicare-med-underpay.pdf; "Financial Health of Hospitals," WakeMed Health & Hospitals, *available at* www.wakemed.org/body.cfm?id=2024.

6 "Uncompensated Hospital Care Cost Fact Sheet," American Hospital Association (January 2014), *available at* www.aha.org/content/14/14uncompensatedcare.pdf; "Financial Health of Hospitals," WakeMed, *supra* n.5.

7 Healthcare Financial Management Association at 2, 13, *supra* n.2.

8 *Id.* at 4. *See also* "Financial Health of Hospitals," WakeMed, *supra* n.5.

by state authorities or related special districts. States with a larger number of teaching hospitals or medical schools fare better in this regard, as bond-rating agencies such as Moody's have noted the strong impact of job creation and the retention benefits of medical facilities that are related to educational institutions.[9] That being said, given the industry shakeout, we believe that in the near term, new construction in the health care sector will focus primarily on urgent care centers (centers that generally will not be built with tax-exempt financing).

Consolidation

Finally, let's discuss the "get big or get out" trend. As previously noted, mid-size hospitals are seeing the most substantial and sustained drop in patient volumes, and the general belief is that those offering between 300-500 beds are in the most vulnerable range. For smaller hospitals, the situation is potentially just as catastrophic, as it appears that the day of the economically efficient 250-bed hospital has all but passed, except perhaps in the smallest and most remote markets, as the economy of scale needed to provide services at this bed level just does not function well in the current slim-margin environment.[10] Similarly, in most major metropolitan areas where the market was once dominated by large standalone hospitals and independent systems, there has been a wave of consolidation over the past five years as large national health systems seek to achieve economies of scale and a broader platform over which to spread costs through acquisitions, not unlike what we saw in the banking industry 15-20 years ago.[11]

The Current State of CCRCs

Although different from hospitals, the senior care and senior-living industry is also quickly evolving and experiencing similar problems and stresses. Nowhere is this similarity with hospitals more acute than with CCRCs. As is the case in the hospital industry, there are more and more consolidations among CCRC operators around the nation, as well as additional stresses on revenue.[12] While independent CCRCs are doing their best to deal with these issues, it appears that there really are two important ingredients necessary to sustain a successful senior facility.

First, successful CCRCs seem to have a "mission":[13] either a faith-based or fraternal organization serves as an anchor to the CCRC community and provides a connection to some larger group that has a purpose for continuing to foster the development of these residential facilities and provide services to them. Second, and perhaps even more importantly, successful CCRCs have a mission-based sponsor that also is well-heeled and well-capitalized.[14] Whether it be a faith-based or a fraternal organization or the beneficiary of some other sponsor, it appears that staying power in the CCRC industry resides with those who independently have the money to continue to support the difficult margins that are being experienced in these developments; this will likely continue until the housing market fully rebounds.

The interrelationship between the fortunes of the housing market and the success of CCRCs only became more obvious with the onset of the financial crisis at the tail end of the last decade. Virtually all of these senior-living retirement communities were designed, at least initially, with a mid-market to upscale audience in mind, with the expectation that as seniors became empty-nesters and sold their family homes, substantial equity would be available in amounts that would be sufficient to pay not only the initial fee to buy into a CCRC, but to also free up enough money for the monthly costs thereafter.[15]

Not surprisingly, the senior-living market has been measurably affected by the housing market crisis since 2008. The economic recession and weakened credit environment has not only limited the CCRCs' access to capital, but it has also had a major impact on the ability of the CCRCs' target audience to sell their homes and otherwise realize the value or income from their investment portfolios. Consequently, as falling real estate values have reduced liquidity and individuals have realized and unrealized losses on their homes, many senior-living facilities have been unable to attract residents who are capable of buying into a retirement community. In addition, many seniors, both those contemplating a move to a CCRC and those already residing there, are further challenged following declines in the value of their general investment portfolios in paying their general monthly living expenses and service fees payable to the housing facilities, separate and apart from the proceeds from the sales of their homes.[16]

Until the economy improves and the housing market fully rebounds (particularly with respect to the upscale residential housing market) allowing seniors to cash the equity in their homes, it would appear that the existing available nonprofit senior-living capacity will not be able to fill existing beds, and demand for new senior-living beds will continue to be weak.

Since these factors will continue to generally squeeze the CCRC and senior-living market for some time, we expect that we will continue to see senior-living facilities needing to restructure their debts and operations, both in and out of bankruptcy court. This trend will be especially prevalent among those that are not strongly mission-based or are otherwise without a financial sponsor that is able to withstand the vicissitudes of the market.

The Current Financing Market

In light of the negative economic pressures on both hospitals and CCRCs, a reasonable question to ask is, what types

9 "Industry Outlook: U.S. Higher Education Outlook Mixed in 2012," Moody's Investor Service, 16 (Jan. 20, 2012), *available at* www.scribd.com/doc/79097920/2012-Outlook-Higher-Education.

10 Healthcare Financial Management Association at 5, *supra* n.2.

11 Bob Herman, "Consolidation Nation: Where Will the Hospital Industry Stand After the Tenet-Vanguard Merger?," *Becker's Hospital Review* (July 24, 2013), *available at* www.beckershospitalreview.com/hospital-transactions-and-valuation/consolidation-nation-where-will-the-hospital-industry-stand-after-the-tenet-vanguard-merger.html.

12 "Older Americans: Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk," U.S. Government Accountability Office (July 21, 2010), *available at* www.gao.gov/products/GAO-10-611 (hereinafter, "GAO Report"); Katherine C. Pearson and Joshua R. Wilkins, "Will Continuing Care Retirement Communities Continue?," *Pennsylvania Bar Association Quarterly* 71 (April 2011), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2019705; Jane E. Zarem, "Today's Continuing Care Retirement Community (CCRC)," CCRC Task Force, 16, 21 (July 2010), *available at* www.leadingage.org/uploadedFiles/Content/Consumers/Paying_for_Aging_Services/CCRCcharacteristics_7_2011.pdf.

13 Elizabeth Olson, "Concerns Rise about Continuing-Care Enclaves," *New York Times* (Sept. 15, 2010), *available at* www.nytimes.com/2010/09/16/business/retirementspecial/16CARE.html?pagewanted=all&_r=0. *See also* GAO Report and CCRC Task Force at 6, *supra* n.12.

14 GAO Report, Pearson and CCRC Task Force at 24-25, *supra* n.12.

15 Olson, *supra* n.13; *see also* GAO Report and CCRC Task Force at 15, *supra* n.12.

16 Olson, *supra* n.13; *see also* GAO Report, Pearson and CCRC Task Force at 22, *supra* n.12.

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of financing are currently being be accessed by these endeavors, and for what purposes? First, it appears that hospitals are reluctant to take on additional debt at this point, even in the current low-interest-rate environment, other than in connection with possible acquisitions or consolidations in the larger marketplace. Potential funding sources, as well as the hospitals themselves, seem to understand the aforementioned trends and economic conditions that result in a low-margin, slim-profit enterprise that is heavily regulated. However, when hospitals do seek financing, they are increasingly turning to the tax-exempt bond market, whether they are for-profit or nonprofit operators. The commercial bond market or standard institutional financing that might have been available to these entities a decade or two ago is not a viable option. Instead, state-sponsored tax-exempt financing, where applicable, with its built-in benefit on investor returns, is needed to entice investors and others to participate in a hospital's financing needs.[17]

Access to the bond market is not free-flowing. For example, so-called safety-net hospitals, typically community-based standalone hospitals, are now almost completely reliant on state and federal transfer payments to sustain their operations.[18] Given that fact, and given the conditions discussed herein with regard to Medicare and Medicaid reimbursements, most of these facilities have extremely tight operating margins, equipment and facilities that border on the obsolete, and are, at the present time, all but foreclosed from accessing the capital markets, even through federally tax-exempt conduit bonds.

With regard to CCRCs, it is also generally true that the vast majority of these facilities — certainly those constructed since the turn of the century — were financed with federally tax-exempt bonds issued by requisite state and local bonding authorities.[19] As previously discussed, economic circumstances since the Great Recession have made it difficult for seniors to move into these facilities because it has been difficult for them to liquidate their investments in their present housing stock. This has led to the need for a great number of these CCRCs to "refinance" their existing bonds through refinancing packages, often done with the same state, federal or local agencies that issued the original bonds. Until the housing market turns around, access to standard institutional financing or to the standard commercial bond market for these facilities will remain challenged, or if it can be accessed, it will be at high rates (even in this otherwise low-interest-rate environment) that are neither competitive nor sustainable within their operational margins.[20]

What's Next?

Given current economic conditions and the challenges to financing, what can we expect to see come down the pike, at least over the next few years, in the restructuring industry for hospitals and CCRCs? Generally, we see three specific types of hospital enterprises and one broad range of continuing care facilities likely to require restructuring services in the future: (1) safety-net hospitals, (2) mid-sized hospitals and (3) hospitals that cannot "get big."

Since safety-net hospitals, especially large nonprofit community hospitals in urban areas, now find that new financing is all but foreclosed to them — even with federally tax-exempt issues handled by state and local authorities — the pressure on them is acute. To survive, and as the marketplace evolves over the next several years in response to consolidation, regulation and pressure on margins, it is hard to imagine that these hospitals will not need help from restructuring professionals as to whether they should try to restructure on their own, combine with other nonprofit enterprises or be converted to for-profit operations (a trend that has been addressed many times before in this column and elsewhere).

Mid-size hospitals are also in the crosshairs. The economics of these under-350-bed hospitals have generally become very problematic, particularly in light of declining patient volume. If these hospitals remain outside of a larger health care system or network, their financing options will likely prove difficult and the stress on their operational circumstances will continue to increase. These economic conditions will affect both nonprofit and for-profit institutions because the economics of scale no longer seem to favor the operation of these smaller facilities. Thus, we expect to see a reduction in the number of these facilities.

There will inevitably be hospitals that will not be targets for acquisition through the current consolidation process as a result of competitive alignment, particularly in metropolitan areas. Size or functional obsolescence might take a hospital out of the consolidation pool, but if excluded, these facilities will be "shaken out" of the system and will be approaching the bankruptcy court and/or the restructuring process for disposition.

As for CCRCs, we believe that there will be a further shakeout in the industry until the housing market fully rebounds. CCRCs that are most likely to see an early need for restructuring will be those without a mission-based foundation or larger fraternal or religious organization with which they are affiliated. Standalone facilities created by local developers and not integrated into a national network or chain of such facilities will likely be the most vulnerable in the near future as the continued inability to garner sufficient seniors to get to a critical mass within the development will prove to be a constant source of financial vulnerability.

Needless to say, this list of future health care restructuring needs is not exhaustive, and this article merely reflects a quick review of some of the circumstances facing hospitals and CCRCs, as well as where we think the stresses on these enterprises will lead. That being said, the stresses are real, and objectively, it does not appear that they will be reversed in the near future. abi

17 GAO Report at 7, *supra* n.12.

18 Lynne Fagnani and Jennifer Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Safety Programs," *Commonwealth Fund*, Publication #351 (October 1999), *available at* www.commonwealthfund.org/publications/fund-reports/1999/oct/the-dependence-of-safety-net-hospitals-and-health-systems-on-the-medicare-and-medicaid-disproporti; "Urban Safety-Net Hospitals in the U.S. Today, Part One in a Series: Financial Challenges to Urban Hospitals," National Association of Urban Hospitals (January 2009), *available at* http://nauh.org/research/raw/2.html.

19 GAO Report and CCRC Task Force at 5, *supra* n.12.

20 CCRC Task Force at 21-25, *supra* n.12.

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